



ONEIDA BAPTIST INSTITUTE

Outstanding. Bold. Inspiring.

Permission to Administer Over-the-Counter (OTC) Medications

Over-the-Counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter." This form is required before over-the-counter medication can be administered at school or in the dormitory. This form is kept on file at the school and will remain effective for the school year indicated. This form must be signed by a physician and renewed each school year.

Student's Name: _____ DOB: _____ School Year: _____

PLEASE INITIAL BY EACH MEDICATION FOR WHICH YOU ARE GIVING OBI PERMISSION TO ADMINISTER

_____ I approve ALL of the medications listed below.

Topical:

_____ Antibiotic cream/ointment (i.e. Neosporin)

_____ Hydrocortisone cream (i.e. Cortaid)

_____ Anti-itch/analgesic cream (i.e. Benadryl)

_____ Burn relief gels

All OTC medication will be given at the manufacturer's recommended dosage.

Oral:

_____ Ibuprofen (i.e. Advil, Motrin)

_____ Acetaminophen (i.e. Tylenol)

_____ Antihistamine (i.e. Benadryl, Zyrtec)

_____ Cough Drops

_____ Cold Medicine (i.e. Dayquil, Mucinex)

_____ Pepto Bismol

PLEASE READ THE FOLLOWING AND SIGN BELOW

The medications indicated above may be administered to my student. I execute my permission voluntarily with full knowledge of its significance and acknowledge that the school has no liability from an injury sustained by a student from receiving an over-the-counter medication listed above which I approved. I have read this consent form and understand all its terms.

SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE

PLEASE INITIAL BY THIS STATEMENT IF YOU DO NOT CONSENT:

_____ I do not want any OTC medications given to my student.

I have reviewed the OTC medications selected above and approve their use at the manufacturer's recommended dosage for the above-named child.

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S NAME: _____

ADDRESS: _____

PHONE #: _____ **EMAIL:** _____