

**Phoenix Country Day School
Off-Campus Over-the-Counter Medication Standing Orders 2008/2009**

Student Name Last _____ First _____ Grade _____

Food or Medication Allergies _____

In case of minor accident or illness during the school day, I authorize the school nurse or representative to be my agent to give my child the over-the-counter medications indicated below, dose appropriate for age and weight of child. I understand that alternate methods of care will be used before medication is given (i.e., eating, resting, ice, etc.). I will not hold PCDS responsible for any reaction my child has to the medications listed below. If any reaction to medication is noted, PCDS will call parent immediately and, in severe reactions, institute "severe allergic reaction" policy. **It is your responsibility to notify the school in writing of any changes to medical conditions or contact information.**

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Acetaminophen (Tylenol)	Pain, headache, cramps
<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen (Motrin, Advil)	Pain, headache, cramps
<input type="checkbox"/>	<input type="checkbox"/>	Naproxen (Aleve)	Pain, headache, cramps
<input type="checkbox"/>	<input type="checkbox"/>	Loratadine (Claritin)	Itching, hives, mild allergic reaction, seasonal allergies
<input type="checkbox"/>	<input type="checkbox"/>	Tums or Mylanta (Ages 12 and up)	Stomach ache
<input type="checkbox"/>	<input type="checkbox"/>	Bismuth Subsalicylate (Pepto Bismol)	Upset stomach
<input type="checkbox"/>	<input type="checkbox"/>	Loperamide Hydrochloride (Imodium)	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Anti-Itch Gel	Insect bites/itchy skin
<input type="checkbox"/>	<input type="checkbox"/>	Cortaid Lotion	Rashes and insect bites
<input type="checkbox"/>	<input type="checkbox"/>	Triple Antibiotic Ointment	Cuts and scrapes
<input type="checkbox"/>	<input type="checkbox"/>	Bactine Spray	Cuts and scrapes
<input type="checkbox"/>	<input type="checkbox"/>	Throat Lozenge	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Anbesol	Gum pain
<input type="checkbox"/>	<input type="checkbox"/>	Student carries inhaler	
<input type="checkbox"/>	<input type="checkbox"/>	Student carries EpiPen	

Signature of Parent/Guardian	Date
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Revised 9.2.08

Off-Campus Supplemental Over-the-Counter Medication Form

Parent is to provide medication in original packaging.

Please complete this form if you wish your child to be given any over-the-counter medications not included above.

My child _____ has taken this over-the-counter medication at home and has had no adverse reaction.

Please administer the following medication(s):

Medication	Dose	Route	Time
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Medication	Dose	Route	Time
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Signature of Parent/Guardian	Date
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