PERMISSION TO ADMINISTER OVER-THE-COUNTER
MEDICATIONS/TREATMENTS

______________________________
Students Name

For this document to be accepted by the PVCICS Health Office, it must have parent/guardian initials throughout the entirety of this document. __________.
INITIAL HERE

THIS DOCUMENT IS VALID FOR THE DURATION OF YOUR CHILD’S ENROLLMENT AT THE PIONEER VALLEY CHINESE IMMERSION CHARTER SCHOOL. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE SCHOOL NURSES IF THERE ARE ANY MEDICAL CHANGES MADE TO THEIR CHILD’S HEALTH HISTORY THAT PROHIBITS THEIR CHILD FROM BEING ADMINISTERED ANY OF THE MEDICATIONS THAT ARE LISTED ON THIS FORM, WHILE AT SCHOOL. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO CONTACT THE NURSES IF THEY WANT TO MAKE ANY CHANGES TO THIS FORM REGARDING MEDICATIONS OR TREATMENTS THAT THEIR CHILD IS PERMITTED TO HAVE DURING THE SCHOOL DAY. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO LIST ALL ALLERGIES TO MEDICATIONS AND/OR INGREDIENTS/DYES THAT MAY BE CONTAINED IN MEDICATIONS ON THIS FORM. IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO NOTIFY THE SCHOOL NURSE IF THEIR CHILD DEVELOPS ANY NEW MEDICATION ALLERGIES OR HEALTH CONDITIONS THAT PROHIBITS THEM FROM BEING ADMINISTERED ANY MEDICATIONS OR TREATMENTS ON THIS FORM.

PLEASE INITIAL TO INDICATE YOU UNDERSTAND AND ACCEPT RESPONSIBILITY TO UPDATE THIS DOCUMENT WHEN YOUR CHILD’S MEDICAL NEEDS, MEDICAL HISTORY, OR MEDICATION ALLERGIES CHANGE DURING THE DURATION OF THEIR TIME IN ATTENDANCE AT THE PIONEER VALLEY CHINESE IMMERSION CHARTER SCHOOL.

INITIAL HERE

If your child has any medication allergies, allergies to ingredients that can be found in medications or allergies to dye (which can be present in medications) please list them here:

1. _____________________________
2. _____________________________
3. _____________________________
4. _____________________________

INITIAL TO INDICATE ALL KNOWN ALLERGIES HAVE BEEN LISTED: __________
The following is a list of Over-The-Counter medications that are available to students in the Health Office. Please indicate by placing a check mark (in the appropriate box next to each medication) to indicate whether you consent to the administration of the following medications, when assessed to be necessary by a registered nurse, to your child during the school day.

- **Acetaminophen** (example: “Tylenol”)
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Ibuprofen** (examples: “Motrin/Advil”)
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Benadryl**
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Cough Drops** (5th grade or above only)
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Saline Solution** (example: Artificial Tears”)
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Petroleum Jelly** (example: Vaseline)
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Lotion** (unscented)
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Calamine Lotion or Caladryl Lotion**
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Hand Sanitizer**
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Salt Water Gargle**
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Sterile Saline** (for Wound Care)
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Cold Application** (ice packs)
  - Yes.
  - No, I do not consent to the administration of this medication while in school.
- **Heat Application** (Heating Pad)
  - Yes.
  - No, I do not consent to the administration of this medication while in school.

Initial to indicate you have reviewed the medications you have approved for your child. __________
If you would like the nurses to call you after the administration of any medications or treatments that are listed on this form, please indicate your wishes below:

**Parent/Guardian Phone Numbers:**

1. Relationship to student: ____________________ Phone Number: ___________________________
2. Relationship to student: ____________________ Phone Number: ___________________________

☐ Yes, I want to receive a phone call every time that my child is given any Over-The-Counter medications during the school day.

☐ No, I do not want to receive a phone call every time that my child is given any Over-The-Counter medications during the school day.

This form only needs to be completed once and will remain valid for the duration of the student’s enrollment at PVCICS. **It is the parent’s responsibility to report any changes in the student’s health that prevents them from having any of the Over-The-Counter Medications on this list to the school nurses.**

We are permitted to administer these medications in school because we have a standing order that is signed by the school physician. We need a medication order from the student’s primary care provider if they require the administration of an Over-The-Counter medication that is not on this list or any prescription medications. The school nurses cannot administer an Over-The-Counter medication that is not on this list or a prescription medication without a signed medication order from the student’s primary care provider.

Please list two emergency contacts that are authorized to pick up your child if they need to go home and we are unable to reach you.

**Emergency contact #1:**
Name: ____________________________________
Phone Number: ____________________________
Relationship to Student: ____________________

**Emergency contact #2:**
Name: ____________________________________
Phone Number: ____________________________
Relationship to Student: ____________________

Please list your child’s primary care provider:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>___________________________________________</td>
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__________________________
Parent/Guardian’s Signature

__________________________
Date

__________________________
Parent/Guardian’s Printed Name