THE SCHOOL DISTRICT OF ESCAMBIA COUNTY
HEALTH SERVICES
J. E. Hall Center 30 E. Texar Dr.
Pensacola, FL 32503
Phone: (850) 469-5456

DISPERSION OF STOCK OVER-THE-COUNTER MEDICATION FORM

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each of the three sections must be completed by parent/guardian for student to receive an over-the-counter (OTC), medication below. **Staff will attempt to notify parents when student receives an OTC medication.**

I. STUDENT INFORMATION

Student's Name	Birth Date	Medication Allergy	Grade

Parent/Guardian	Address

Home Phone	Work Phone	Cell Phone

II. ACTION PLAN (To Be Completed By Parent/Guardian). Please complete all spaces. Check yes or no to indicate which of the approved list of over-the-counter medications may be administered when indicated by student's symptoms.

THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 20____-20_____ OR EARLIER STOP DATE:_____

Over-the-Counter Medication	Dosage and Time	Condition/Symptoms	Possible Side-Effects*	Comments
Acetaminophen (Tylenol ®) ☐Yes ☐No	Administer according to the manufacturer's label	For relief of minor aches & pain; fever (100.5°) will not be treated at school unless nursing assessment indicates need for treatment of 102° or higher temperature while awaiting transportation home.	None significant if administered per manufacturers label	**Alert:** Students with temperature over 100.4° must be sent home.
Calcium Carbonate (Tums ®) ☐Yes ☐No	Administer according to the manufacturer's label	For stomach ache or heart burn	Constipation	Not to be used in children less than 6 years old.
Diphenhydramine (Benadryl ®) ☐Yes ☐No	Administer according to the manufacturer's label	For allergy symptoms	Drowsiness or excitability	**Alert:** Students will not be allowed to drive within 4 hrs. of taking Benadryl.
Ibuprofen (Advil ®, Motrin ®) ☐Yes ☐No	Administer according to the manufacturer's label	For relief of body aches & pain or menstrual cramps; fever (100.5°) will not be treated at school unless nursing assessment indicates need for treatment of 102° or higher temperature while awaiting transportation home.	Stomach upset	**Alert:** Contains no aspirin (salicylates), but should not be given if student has allergy to aspirin; may cause stomach bleeding.
Sting Relief Pad™ Contains 2% Lidocaine For External Use Only ☐Yes ☐No	Administer according to the manufacturer's label	For temporary relief of pain and itching caused by insect bites and stings	None significant if administered per manufacturers label	Do not use on broken skin, near eyes or mucous membranes.

***Manufacturer's label is maintained in the clinic for parents to review upon request**

III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian). Form is void if this section is incomplete.

I request the designated school personnel or its agents to assist my child in the administration of the above described medication/s. I give permission for my child to take the medication indicated above by my checking the yes box according to the condition/symptoms described while in school or while participating in school activities away from the school site. I understand that: (1) there is no liability on the part of the school district, its personnel, or agents, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) these medications are stocked and maintained by school clinic, as available, with standing orders prescribed by the contracted vendor's Medical Director; (3) An attempt will be made to notify me of the medication and time that the OTC medication was administered to my child; (4) I will be contacted if my child's symptoms do not improve and s/he is unable to remain at school. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of the Escambia School District and its agents. Furthermore, if my child is covered by Medicaid and receives services under an IEP or any other plan, I consent for the school district to bill Medicaid for those services.

Parent/Guardian Signature: _____ Date: _____

Students are not allowed to bring or carry <u>any</u> over-the-counter medications to school or school sponsored activities.