Sault Ste. Marie Public Schools
Authorization form for Over the Counter
Medications approved by physician & parent/legal guardian

Student's name: ___________________  School: ______________________
Birth date: ___/___/_______  Name of Physician____________________

Please check box of what you approve
Following directions as indicated on box or bottle for age & or weight

**Headache, fever or pain**
Children's Tylenol or ibuprofen or Midol

**Upset stomach**
Children's Pepto Bismul/Tums/Rolaids

**Allergy**
(sneezing, watery eyes, runny nose, itchy throat) Benadryl (diphenhydramine HCL 25 mg)

**Cough or sore throat**
Cough drops

**Diarrhea/loose stools**
Anti-diarrheal (loperamide HCL 2mg)
Not for 6 year olds and younger or under 47 pounds.

**Eye drops**
For eye debris or irritation

**Rash or itchy skin**
Wash, dry, apply skin lotion if dry skin or hydrocortisone cream if itchy, or Vaseline or petroleum jelly to soothe an abrasion once clean.

**Mouth & or lips Medication**
Canker sore medication lip balm

Physician / Nurse Practitioner signature: _______________________________________

Parent / Legal Guardian signature: ____________________________________________

Physician Permission to self carry if SAHS student _______________________________