Langley High School Orchestra OTC Medication Authorization

Printed Student LAST Name: _____ First: _____

~I have authorized administration of over-the-counter (OTC) medications listed below. Any FCPS staff, nurse, or parent chaperones may provide the following medications to my student if required and/or requested. My student has never had an allergic reaction to the medications I have authorized.

~I have also filled out FCPS Medication Authorization form SS/SE-63. I understand that this form is only a supplement to form SS/SE-63.

Chaperones will have access to the OTC products noted below available to administer to students. For each entry, you must check either a "Yes" or "No". ***Do not leave blanks.***

Bacitracin ointment with dressing changes for wounds
YES ___ NO ___
Benadryl, diphenhydramine, 25-50 mg, every 4 hrs for allergic reactions
YES ___ NO ___
Cepacol throat lozenges, 1-2 every 4 hrs for sore throat or cough
YES ___ NO ___
Hydrocortisone cream 2% for insect bites or itches
YES ___ NO ___
Ibuprofen, Advil or Motrin, 200-400 mg, every 4 hrs for pain or fever
YES ___ NO ___
Sudafed, pseudoephedrine, 30-60 mg, every 6 hrs for head congestion
YES ___ NO ___
Tums, calcium carbonate antacid 500 mg, 2-4 tablets every 4 hrs for upset stomach
YES ___ NO ___

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____

Parent/Guardian Cell #: _____

Date: _____