SPARTANBURG COUNTY SCHOOL DISTRICT FOUR
WOODRUFF HIGH SCHOOL
OVER THE COUNTER MEDICINE GUIDELINES
AND
PERMISSION

Student Name: _____Grade:_____DOB_____

I give permission for my child to have the following over the counter medicines while at school as needed and prescribed by the school physician.

- Acetaminophen/Tylenol _____Yes _____No
- Diphenhydramine HCL/Benadryl _____Yes _____No
- Calamine/Caladryl Lotion _____Yes _____No
- Calcium Antacid Tablet/Tums _____Yes _____No
- Clotrimazole/Ring Worm Ointment _____Yes _____No
- Hydrocortisone Cream _____Yes _____No
- Ibuprofen _____Yes _____No
- Nonneomycin Containing Polysporin Ointment _____Yes _____No
- Orajel/for minor toothache _____Yes _____No

The medicines above must be brought to the school and given to the nurse in the **ORIGINAL** Medicine labeled bottle. The nurse will then label the medicine with student's name. The nurse will administer the medicines as needed.

Any other medicines "**Over the Counter or Prescription Medicines"** must have a parental permission slip filled out as well as a prescription from their medical doctor.

All expired medicine will be discarded by the nurse. You will be notified to send in new medicines.

_____ _____

Parent/Guardian Signature **Date**