



Over-the-Counter (OTC) Medicine Authorization

The following section is to be completed by the **PARENT/GUARDIAN** for the administration or providing of medication. Medications must be in original containers.

Child's Name: _____
Last First Sex DOB Grade

OTC Medicine Informed Consent and Authorization

I hereby consent and authorize Blessed Trinity Catholic School ("School"), its administrators, teachers, and authorized school personnel to store, administer and/or provide the over-the-counter ("OTC") medications I select below, in accordance with the manufacturer's label directions for age and weight. I acknowledge that school personnel act in good faith and that emergency care rendered in good faith is afforded protection under Florida law. I consent the School taking all actions reasonably deemed necessary to safeguard my child's health, including consulting with emergency medical personnel and authorizing treatment pursuant to § 743.0645, Florida Statutes, if I cannot be reached.

I assume full responsibility for providing OTC medications in original, unopened containers with intact labels, for monitoring expiration dates, and for promptly replacing medications as required. I agree to indemnify and hold harmless the School and its employees from claims or costs arising out of my failure to do so, or arising from medications that are mislabeled, defective, or expired. I understand and acknowledge that OTC medications carry risks of side effects or allergic reactions even when taken as directed. This authorization reflects my agreement and informed consent for the School and its employees to act in reliance on this authorization.

OTC Medications Authorized (check all that apply)

- ☐ Acetaminophen (e.g. Tylenol – pain/swelling)
- ☐ Ibuprofen (e.g. Advil, Motrin – pain/swelling, with food)
- ☐ Antacid (e.g. Tums, Rolaids, Maalox – stomach upset/indigestion)
- ☐ Antihistamine, non-drowsy (e.g. Zyrtec [cetirizine], Claritin [loratadine] – allergies)
- ☐ Diphenhydramine (e.g. Benadryl – allergic reaction; not for routine cold use)
- ☐ Cough drops/lozenges (e.g. Halls, Ricola, Cepacol – sore throat/cough relief)
- ☐ Saline spray/eye drops (e.g. Ocean Spray, Simply Saline, Refresh – nasal or eye irritation)
- ☐ Topicals: (e.g. hydrocortisone 1% cream (Cortizone-10), bacitracin (Neosporin))
- ☐ Other (name/dose): _____

Acknowledgment: I have read and reviewed the School's policy and agree to comply with its requirements.

Parent/Guardian Name: _____

Relationship to student: _____

Signature: _____ Date: ____ / ____ / ____



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Aspirin Notice: The School will not administer aspirin (acetylsalicylic acid) to students absent a physician's written order due to risk of Reye's syndrome.

Emergency Protocols: OTC medications will **not** be administered if symptoms suggest a serious illness or injury (e.g., fever $\geq 100.4^{\circ}\text{F}$, difficulty breathing, chest or abdominal pain, head injury, seizure). In such cases, the School will contact the parent/guardian and may recommend medical evaluation. Emergencies will trigger call to 911.

Emergency Contacts

Primary Contact: _____ Phone: _____

Secondary Contact: _____ Phone: _____