Northmont City Schools
4001 Old Salem Road
Englewood, Ohio 45322

Administration of Supplied Over the Counter Medication on an Overnight Trip

Each locked medication bag will have a supply of acetaminophen, ibuprofen, antacid and antihistamine, such as Benadryl. Generic Benadryl will be used for an emergency use only. These will be adult strength tablets in a generic brand. *These are provided for occasional use.*

Name of Student ____Student Birthdate_______________

Name of School ___________________________________ Grade/Teacher/Team __________________

My child may take the following medication on the trip. *I understand that non-medical school personnel may administer these medications.* This authorization will be in effect for the current trip unless revoked in writing by the parent/guardian. **Bottle directions for age/weight will be followed to determine the dosage. (Please check mark below)**

_____ Acetaminophen (325mg generic Tylenol)

_____ Ibuprofen (200mg)

_____ Antacid

_____ Antihistamine (*Emergency* use only 25mg generic Benadryl)

Parent/Guardian signature_______________________________ Date____________________

Cell Phone____________________________Daytime phone_______________________

FOR SCHOOL USE

Date	Medication	Dose	Time	Reason	Initials

***School Employee Signature**____________________________________**Initials**________

OVER>>>>>

Northmont City Schools
4001 Old Salem Road
Englewood, Ohio 45322

Administration of Over the Counter Medication on an Overnight Trip

Name of Student ______________________________________Student Birthdate__________________

Name of School _________________________________Grade/Teacher/Team_____________________

My child may take the following medication on the trip. *I understand that non-medical school personnel may administer these medications.* This authorization will be in effect for the current trip unless revoked in writing by the parent/guardian. **Bottle directions for age/weight will be followed to determine the dosage.**

As the parent/guardian, I will supply the following **over the counter medication** for my child to take as needed. I understand that the school district maintains the right to restrict the use of this form for certain over the counter medications.

Name of medication ____

How many__________________________ How often _________________________

Parent/Guardian signature________________________________ Date_____________________

Cell Phone_____________________________Daytime phone_______________________

FOR SCHOOL USE

Date	Medication	Dose	Time	Reason	Initials

***School Employee Signature**_____________________________________**Initials**_________