

OVER-THE-COUNTER MEDICATION PERMISSION FORM

I, _____, hereby give permission for the Fairview Heights Church of
(Parent/Legal Guardian)
Christ, together with its adults in charge, to administer the following over-the-counter medications if they deem
it necessary to _____. Dosages will be administered according to the
(Child's name)
directions on the label unless otherwise directed by a physician.

Please circle any of the medications below that your child may **NOT** receive.

Complaint	Treatment
Headache, Fever, Pain	Acetaminophen or Ibuprofen
Abdominal Discomfort/Gas	Maalox
Allergic Reaction	Benadryl
Bug Bites	0.5% Hydrocortisone Cream or Benadryl
Cold Sores	Blistex
Constipation	Milk of Magnesia
Nausea	Pepto-Bismol
Diarrhea	Pepto-Bismol
Cough; progressive	Cough Medicine
Cough; non-progressive	Robitussin or Robitussin DM
Cramps, Menstrual	Ibuprofen or Midol
Head Lice	RID or Equivalent
Muscle Aches	Ben Gay or Analgesic Ointment
Poison Ivy, Oak, Sumac	Calamine Lotion, 0.5-1% Hydrocortisone
Ringworm	Lotrimin or Tinactin
Sore Throat	Throat lozenges or throat spray
Motion Sickness	Dramamine

Signed _____ Date _____
(Parent/Legal Guardian)