

Contoocook Valley School District

Consent for Over the Counter Medication Administration

ConVal Regional High School 184 Hancock Road Peterborough, NH 03458

Telephone # (603) 924-3869

Fax # (603) 924-0046

Student Name _____

DOB ____/____/____

School Year 2019-2020

*I give permission for my child to receive any medication checked below on this form.
I understand that generic equivalent medications may be used.*

Medications/First Aid Product:

____ Acetaminophen (e.g. Tylenol)

____ Aloe

____ Antacids (e.g. Tums)

____ Bacitracin Ointment (antibiotic ointment)

____ Benzocaine Wipes (for bee stings)

____ Calamine Lotion/Spray (for itchy rashes)

____ Diphenhydramine (aka Benadryl - for emergency use only)

____ Hydrocortisone Cream 1% (for itchy rashes)

____ Ibuprofen (e.g. Advil/Motrin)

Please indicate any known medication/food/environmental allergies:

Parent/Guardian Signature _____

Date ____/____/____

This consent form must be on file in your child's health folder and must be updated each school year.