The Arrowhead Union High School District

South Campus/District Office
700 North Avenue
Hartland, Wisconsin 53029
(262) 369-3611 x4108 Health Room

North Campus
800 North Ave.
Hartland, Wisconsin 53029
(262) 369-3612 x4208 Health Room

http://www.ahs.k12.wi.us

OVER-THE-COUNTER MEDICATION CONSENT FORM

Name of Student_____ **Grade**_____

- **No over-the-counter medication will be given to students without written permission from parent, legal guardian or a student who is 18 years old.**
- **Written consent for over-the-counter medications is good for the entire time the student is at AHS.**
- **Arrowhead Union High School will supply generic ibuprofen, generic acetaminophen and diphenhydramine hydrochloride (generic antihistamine).**
- **All other medications must be brought in from home in the original containers and stored in the locked cabinet in the health room.**
- **Instructions may not exceed manufacturers recommended dosages.**

_____ **Ibuprofen 200mg**, (generic Advil) 1 or 2 tablets every 4 hours as needed for discomfort. **AHS has a supply in the health room.** Ibuprofen will not be administered over 10 days a month without documentation from a physician.

_____ **Acetaminophen 500mg** (generic Tylenol), 1 or 2 tablets every 4 hours as needed for discomfort. **AHS has a supply in the health room.** Acetaminophen will not be administered over 10 days a month without documentation from a physician.

_____ **Diphenhydramine Hydrochloride 25 mg** (generic antihistamine) 1 or 2 capsules every 4 hours as needed for allergic reaction or hay fever. **AHS has a supply in the health room.**

Medications selected below must be supplied by parents and will be stored in the Health Room:

_____ **Acetaminophen (Tylenol) 325 mg**, 1 or 2 tablets every 4 hours as needed for discomfort.

_____ **Aleve 220mg,** 1 caplet every 12 hours as needed for discomfort.

_____ **Midol** (500 acetaminophen, 60 mg caffeine & 15 mg pyrilamine maleate) 1 or 2 capsules every 6 hours as needed for menstrual cramps.

_____ **Name of Medication**_____ Dosage_____ as needed prn.

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A. I hereby give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my child according to the directions stated above.
B. I give my permission to the school nurse to contact the student's physician.
C. I further agree to hold the Arrowhead School District, and the above-identified person(s) harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.
D. I agree to notify the health room at the termination of this request or when any change in the above orders is necessary.

_____ _____

Signature of parent/legal guardian/18 year old student **Date**