THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER
BRIARCLIFF MANOR, NEW YORK 10510

OVER THE COUNTER MEDICATION PERMISSION FORM

Student's name:_____ **Date:** _____

Allergies:_____ **Date of Birth:** _____

The following medications will be provided by The Clear View School if they have been approved by the child's physician/provider (signature is required) and requested by the guardian; please indicate by checking Yes or No next to medication.

Yes/No	Drug Name	Route	Dosage & Schedule	Indications	Comments
Yes☐ No☐	Tylenol (or generic) acetaminophen	PO (chewable, elixir, or tabs)	Per label instruction by age/weight	Pain or Fever	Call parent/guardian event of fever
Yes☐ No☐	Advil (or generic) ibuprofen	PO (chewable, elixir, or tabs)	Per label instruction by age/weight	Pain or Fever	Call parent/guardian event of fever
Yes☐ No☐	Benadryl (or generic)	PO (elixir, or tabs)	Per label instruction by age/weight	Allergic reactions (hives, insect bites)	Call if allergic reaction, respiratory problems
Yes☐ No☐	Cepacol lozenges or (generic) (contains benzocaine)	PO	Per label instruction by age/weight	Sore throat	Check allergy history
Yes☐ No☐	Tums or (generic) calcium carbonate	PO (chewable)	Per label instruction by age/weight	Indigestion, heart burn	
Yes☐ No☐	Pepto Bismol	PO (chewable, elixir, or tabs)	Per label instruction by age/weight	Upset stomach, nausea, diarrhea, indigestion	
Yes☐ No☐	Oragel/ Anbesol (or generic, contains benzocaine)	PO	Per label instruction by age/weight	Toothache, sore gums canker sore	Check allergy history
Yes☐ No☐	Hydrocortisone Cream 1%	Topical	Per label instruction by age/weight	Allergic reactions (contact dermatitis, insect bites	
Yes☐ No☐	Calagel	Topical	Per label instruction by age/weight	Poison oak, poison ivy	
Yes☐ No☐	Medicaine Sting Swabs (contains benzocaine)	Topical	Per label instruction by age/weight	Insect bites, bee stings	
Yes☐ No☐	Antibiotic Ointment	Topical	Per label instruction by age/weight	Superficial cut/ abrasion	Check allergy history
Yes☐ No☐	Silvadene 1%	Topical	Per label instruction by age/weight	Burns	Check allergy history / sulfa antibiotic

Physician/Provider Signature:_____ **Date:**_____
Physician/Provider Stamp: (required):

Parent/Guardian Signature_____ **Date:**_____