Arlington High School Marching Band

Over the Counter Medication Form

Student Name: ________________________________Date of Birth___________
Allergies To Medication:____

The following medications are approved for use by the primary physician. The student may self–administer these medications with supervision as instructed below if approved by the parent/guardian. **The parent/guardian must sign his/her initials in the left hand column next to each medication that he/she wishes to be dispensed for the indications listed.** If the physician or parent/guardian do not wish for any of the medications listed to be utilized, please cross that medication off of the list. This form will be valid for the duration of the current Marching Band Season.

This form must be signed by the parent and the primary physician to be valid.

Parent Initial	Drug Name	Route	Dosage & Schedule	Indications	Comment
	Acetaminophen/ Tylenol	PO	325 mg, 2 Tabs 500 mg, 1 Tab 500 mg, 2 Tabs **CIRCLE DOSE**	Pain or Fever >_____	
	Ibuprofen	PO	200 mg, 1 Tab 200 mg, 2 Tabs **CIRCLE DOSE**	Pain or Fever >_____	
	Benadryl	PO (Elixir, Chewable, tablets, melt-away strips)	12.5 mg 25 mg **CIRCLE DOSE**	Allergic Reactions including insect bites, hives, seasonal allergies	
	Antibiotic Ointment	Topical	Per label instruction	Superficial cuts/Abrasions	
	Hydrocortisone Cream	Topical	Per label instruction	Allergic Reactions, contact dermatitis, insect bites, poison ivy/oak/sumac	
	Benadryl Cream	Topical	Per label instruction	See Hydrocortisone instructions	
	PABA-Free Sun Block (Must be provided by parent)	Topical	Per label instruction	To prevent sunburn during outdoor activities	
	Cough Drops/Throat Lozenges	Oral	Per label instruction	To relieve sore throat	

Physician Signature:______________________________Date:_________________

Parent Signature:________________________________ Date:_________________