Tuscola Community Unit School District #301

409 S Prairie
Tuscola, IL 61953

217-253-4241 (p)
217-253-4522 (f)

OTC (Over the Counter) Medication Physician Order Form

Student _____

Grade/Teacher _____

1) Both parent consent and physician authorization is required.
2) Medication will not be given more than once per day nor exceeding the recommended dose.
3) A new OTC order form needs to be completed and signed by parents and physician each school year.

4) Tuscola CUSD No. 301, and its employees and agents, and any physician providing a standing protocol or prescription for OTC medication, are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the pupil's self-administration or use of an OTC medication by the pupil regardless of whether authorization was given by the pupil's parents or guardians or by the pupil's physician, physician's assistant, or advanced practice registered nurse.

The parents/guardians of the pupil named below acknowledge that Tuscola CUSD No. 301 and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of OTC medication by the pupil regardless of whether authorization was given by the pupil's parents or guardians or by the pupil's physician, physician's assistant, or advanced practice registered nurse and that the parents or guardians must indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication or use of an OTC medication by the pupil regardless of whether authorization was given by the pupil's parents or guardians or by the pupil's physician, physician's assistant, or advanced practice registered nurse.

5) For chronic problems, parents may be asked to supply their own OTC medication.

If you wish for your child to receive the following medications and /or treatments at school, please check, sign and date below. **Your child's physician or healthcare provider must also sign and date for this to be valid.**

___Ibuprofen
___Acetaminophen
___Antacid Tablets (Turns)
___Benadryl (diphenhydramine)
___First Aid Gel (Staphaseptic)
___Visine/Murine eye drops
___Orajel (gum pain)
___Triple Antibiotic Ointment
___Burnjel
___Hydrogen Peroxide
___Hydrocortisone Cream
___Bee sting swabs
___Rubbing Alcohol
___Mineral Ice/Ben-Gay
___Glucose Tabs
___Saline Solution
___Cough drops
___Midol
___Vaseline
___Zyrtec

Parent Signature _____ Date _____

Print Name _____

Physician Signature _____ Date _____

Physician Phone # _____

Print Physician Name & Address _____