Student's Name _____

PERMISSION TO DISPENSE MEDICINE FORM

St. Vincent's sponsors will be in charge of basic first aid and dispensing medication. They will take basic over-the-counter medications. The majority of the students who may need health assistance will require no more than minor first aid or treatment, which you provide for your child at home. The problems of which the students may complain will be headaches, sore throats, stomachaches, and diarrhea. Listed on the form below are the medications that will be available.

Students will not be allowed to carry any medication except for those needed in an emergency, i.e. rescue inhalers for asthma, EpiPens for severe allergic reactions. Students will only be allowed to carry these medications with parental permission.

All medications, prescription and over-the-counter, must be in the original bottle/packaging with labels and instructions. List these medications below with directions and times to be given. ONLY INCLUDE AMOUNT OF MEDICATION NEEDED FOR THE TRIP PLUS ONE EXTRA DAY.

- **Circle all** medications that your child **may take**
- Please send a doctor's note for the child's over-the-counter medication, **if** the treatment differs from the label.
- **DO NOT** send these medications – we will provide these.

My child, _____, has my permission to take:

	Medication	Dosage (per label directions)
1	Acetaminophen (Tylenol) 325mg	2 tabs every 4-6 hrs. as needed
2	Ibuprofen (Advil/Motrin) 200mg	1 tab every 6-8 hrs. as needed
3	Diphenhydramine (Benadryl) 25mg	1 tab every 6-8 hrs. as needed
4	Dramamine 50 mg (for motion sickness)	1 tab every 4-6 hrs. as needed
5	Robitussin Cough+Chest Congestion DM (Dextromethorphan/Guiafenesin)	10ml every 4 hrs. as needed
6	Anti-Diarrheal (Imodium A-D) 2mg	2 tabs after 1st loose stool; 1 tab after each subsequent loose stool – no more than 4 tabs/24hrs.
7	Tums	1-2 tabs as needed – no more than 6 tabs/24hrs.
8	Triple Antibiotic Ointment	Apply to affected area 1-3 times daily as needed
9	1% Hydrocortisone Cream	Apply to affected area 3-4 times daily as needed
10	Cough Drops	1 lozenge every 2 hrs. as needed

List all medications ***(prescription & over-the-counter), including vitamins***, that your child will be bringing on the trip. Please include directions for the medication.

_____

_____

_____

_____

*** PLEASE TURN IN MEDICATION TO WHOMEVER IS IN CHARGE!

Parent/Guardian Signature: _____ Date: _____

Parent phone number(s): _____

Form Updated 10/31/16