# ELEMENTARY SCHOOL FIRST AID FORM

Student Name: ______________________________________ Date of Birth: __________________

I ______________________________________________________ give Lake Norman Charter's nurse or
(Parent or Guardian name)
health room staff permission to administer the over the counter first aid supplies indicated below for my student named above. I understand and accept that Lake Norman Charter School, its employees, agents and/or designees are not responsible for any side effects or reactions of the supplies/OTC medications I have approved on this form to be used for my student. I understand that once I complete this permission form, withdraw of permission must be done in writing.

Write your initial on the appropriate line of each item you approve to be used on your student for first aid.

_____Cough Drops _____Saline Eye Rinse _____Vaseline/Aquaphor

_____Antacid _____Wound Wash (Bactine) _____Allergy Eye Drops

_____Sunscreen _____Antibacterial Ointment _____Bug Spray

_____Oragel _____Anti Itch Gel _____Hydrocortisone Cream

_____Afrin Nasal Spray (for treating nose bleeds) _____Bandages

Over the counter medications; dosage determined based on weight of student.
_____Ibuprofen Oral Suspension 100mg per 5ml My students current weight___________________.
_____Acetaminophen Oral Suspension 160mg per 5ml My students current weight_____________.
_____Diphenhydramine HCI (Benadryl) 12.5mg per 5ml My students current weight____________.

*Students with permission for the these over the counter medications will be weighed periodically when medications being administered and their dosage for these medications will be adjusted according to medication dosage (by weight) instructions.

Parent/Guardian PRINTED Name:_____________________________________________________

Parent/Guardian Signature: __________________________________________ Date:__________

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