PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF

OVER- THE- COUNTER MEDICATION IN SCHOOL & SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child _____DOB_____ Grade _____receive the following over- the -counter medication as prescribed below by our physician. The medication is to be furnished by me in the original unopened sealed container.

Signature (Parent or Guardian) _____

Telephone: Home_____ Work_____ Date_____

B. <u>To be completed by physician:</u>

I request that my patient, as listed below, receive the following over –the- counter medications:

Name of Student_____ DOB_____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION
calamine lotion			
antibiotic ointment			
petroleum jelly			
Anbesol/orajel			
sting relief pads			
Benadryl cream			
Tylenol(**must be provided by parent)**			
Advil**(must be provided by parent)**			
Benadryl**(must be provided by parent)**			
Cough drops			
Cough syrup **(must be provided by parent)**			
Chloraseptic Sore throat spray			

Duration of Treatment: FOR ONE YEAR

Possible Side Effects & Adverse Reactions (if any):_____

<u>Physician's Signature</u>_____ Date: _____

Address: _____ Phone: _____

*Medication must be in the original unopened sealed container and brought in by Parent, Guardian or responsible adult.

Plan reviewed with parent(s)/ guardian(s):

Parent Signature: _____ Date: _____