

**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. To be completed by physician:

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			
Sting relief pads			
Hydrocortisone cream			
Tylenol(must be provided by parent)			
Advil(must be provided by parent)			
Benadryl(must be provided by parent)			
Cough drops			
Burn Spray			

Duration of Treatment: FOR ONE YEAR

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

Physician's Signature _____ **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:** _____