

Student: _____ D.O.B.: _____

School Year: September to June

MEDICATION ADMINISTRATION PERMISSION - P.R.N. (as needed/ over-the-counter OTC)

- All medication doses will be **given as per the directions on the box/bottle/package provided based on age, recommended frequency, and weight of your child** unless otherwise prescribed/documented and initialed below by your Physician.
- Medication must be given to the School Nurse in **OTC original labeled packaging.**
- Medication shall be administered by the School Nurse only upon **signed order of the prescribing physician and by request of the parent as signed/checked below.**

SORE THROAT / COUGH / ANTACIDS / HIVES

- Cough drops (e.g. Halls) _____ Sore Throat Spray _____
- Antacids (e.g. Tums) _____ Allergic Reaction/Hives (e.g. Benadryl) _____

PAIN (Headache, Menstrual cramps, Muscle strains etc.) or FEVER (102°F or higher)

- Tylenol _____ Advil _____
- Ibuprofen _____ Orajel _____
- Pain relieving gels (e.g. Icy-hot/Biofreeze) _____ Other _____

EYE DISCOMFORT (Seasonal allergies)

- Eye drops (e.g. Visine) _____ Contact Lens solution _____

PARENT PERMISSION

- I hereby give permission for the school nurse to administer medication I have provided for use, to my child as directed by the physician.
- I wish to be called before administration of any oral medications to my child: **Phone #**.....
- Signature of Parent/Guardian Print Name

PHYSICIAN PERMISSION

- I hereby give permission to the school nurse to administer the medication/s as checked by the parent above for p.r.n. treatment. Doses will be **given as per the directions on the original OTC container provided, based on age, recommended frequency, and weight of the child unless otherwise prescribed and initialed above by physician.**

Signature of Physician

..... & ADDRESS STAMP

