# Authorization for Over-the-Counter Medications

*All OTC medications must remain in their original container*

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|---|---|
| Child's name | |
| Physician's name | |
| Physician's address | |
| **Acetaminophen/Tylenol** | |
| Physician's initials ________ | Form (pill, liquid, etc.):_______________ Dose:_________________<br>May be given every 4-6 hours for headache or general discomfort |
| **Ibuprofen/Motrin** | |
| Physician's initials ________ | Form (pill, liquid, etc.):_______________ Dose:_________________<br>May be given every 6 hours for headache or general discomfort |
| **Diphenhydramine/ Benadryl** | |
| Physician's initials ________ | Form (pill, liquid, etc.):_______________ Dose:______ |
| **Calcium Carbonate/Tums** | |
| Physician's initials ________ | Dose:________<br>May be given once at school for indigestion. |

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|---|---|---|---|
| *Physician's Signature* | | *Date* | |

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| In addition to the physician's instructions above, I hereby authorize the School Nurse, Principal, or Secretary to administer the following remedies to my son/daughter. | |
| ☐ | Cough drops |
| ☐ | Saline eye drops |
| ☐ | Anti-itch lotion |
| ☐ | Neosporin |
| Choose one: | ☐ *I wish to be called before medication is administered*<br>☐ *Please administer the medication, then inform me via email* |

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|---|---|---|---|
| *Parent's Signature* | | *Date* | |