Authorization for Over-the-Counter Medications

All OTC medications must remain in their original container

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

Physician's Signature		*Date*	
Choose one:	☐ *I wish to be called before medication is administered* ☐ *Please administer the medication, then inform me via email*		
Parent's Signature		*Date*	