



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			
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:	<input type="checkbox"/> <i>I wish to be called before medication is administered</i> <input type="checkbox"/> <i>Please administer the medication, then inform me via email</i>		
Parent's Signature		Date	