Mendham Township Elementary School

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AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS (OTC) DURING SCHOOL HOURS

Student Name: _____ Date of birth: _____ Grade: _____
Parent/Guardian Name: _____
Home Address: _____
Parent/Guardian Phone: Home: _____ Cell: _____ Work: _____

I request that my child be administered the following OTC medication(s) by the school nurse if needed throughout the current school year as directed by my child's medical provider below. Medical authorization forms are effective for the school year in which the order was written. New forms must be submitted each school year.

Parent/Guardian Signature: _____ Date: _____

This section for completion by Licensed Medical Provider: **(STAMP)**

LMP Name: _____
Address: _____
Phone: _____

The following OTC medications will be stocked in the school health office: Acetaminophen liquid (160mg/5ml), Acetaminophen tabs (325 mg/tab), Ibuprofen liquid (100mg/5ml), Ibuprofen tabs (200mg/tab), Diphenhydramine HCl/Benadryl liquid (12.5mg/5ml), Diphenhydramine HCl/Benadryl tabs (25mg/tab), Tums Regular strength tabs

Medication: _____ Route: _____ Dosage: _____
Frequency: _____ Reason for use/signs & symptoms: _____
List side effects and/or contraindications: _____

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