

LEARNING PREP SCHOOL
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Medication Permission Form for Over –The- Counter Medication

*This form **must** be completed by the physician/ licensed prescriber **and** parent.*

Student's Name: _____

DOB ____/____/____

Physician/Licensed Prescriber: Please Circle all that apply:

Medication	Dosage	Time to be administered	Possible side effects	Diagnosis or condition
Tylenol	As directed	by mouth every 4hrs	liver complications with excessive use	Pain/fever/headache
Ibuprofen	As directed	By mouth every 6-8hrs	Abdominal pain	Pain/fever/headache
Benadryl	As directed	by mouth every 6-8hrs	drowsiness	Allergy symptoms
Cough Drops	As directed	by mouth every 1-2hrs		Cough
Bacitracin	topical	As needed		Minor cuts/abrasions
Calamine	topical	As needed		Itching, skin irritation
Hydrocortisone Cream 0.5%	topical	As needed		Itching, skin irritation
Other:				
Other:				

Comments: _____

Date

X _____
Signature of Physician/ Licensed Prescriber/ Title

Telephone

Address

Parent or Guardian:

I, the undersigned, give permission to the school nurse to administer to my child in taking the above medication. I understand that school personnel are not responsible for any problems arising from the taking of this medication or its side effects.

Date

X _____
Parent/Guardian Signature

Student Signature (if over 18 yrs of age)

Parent **email** address _____

Under Massachusetts General Laws (M.G.L.) Chapter 112, 80B, a licensed nurse must have a medication order from a physician, dentist, nurse practitioner, or physician's assistant in order to administer any medication, whether it is a prescription drug or over-the-counter medication.