LEARNING PREP SCHOOL

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Medication Permission Form for Over –The- Counter Medication

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

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 as needed	liver complications with excessive use	Pain/fever/headache
Ibuprofen	As directed	By mouth every 6-8hrs as needed	Abdominal pain	Pain/fever/headache
Benadryl	As directed	by mouth every 6-8hrs as needed	drowsiness	Allergy symptoms
Cough Drops	As directed	by mouth every 1-2hrs as needed		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
Tums	1-2 tabs	As needed		Stomach upset
Other:				

Comments:____
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______________ X____

Date *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.

________________ X _________________________________

Date ***Parent/Guardian Signature***

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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.