Over the Counter Medication Permission

MANDATORY FORM TO BE SIGNED AND RETURNED

New York State Education Law requires prior written approval from both a healthcare provider and the parent/legal guardian for over-the-counter medication ("OTC") administered in school. Therefore, if your student needs OTC medication, please complete this form and supply the OTC medication for your student.

Student's Name: _____ **DOB:** _____ **Allergies:** _____

Medication	Indications for use and conditions under which medication should be administered. Please add indications if needed	Dosage and Route of Medication	Frequency and/or Time	Health Care Provider Consent (Please Initial)	Parent/ Legal Guardian Consent (Please Initial)
Acetaminophen Elixir (160mg/5ml)	Headache, pain or fever>101° F	_____ mg po	Q 4-6 H PRN		
Acetaminophen (325mg Tablets)	Headache, pain or fever>101° F	_____ mg po	Q 4-6 H PRN		
Anti-itch lotion (Caladryl/Calamine)	itching	1 Topical application to site	Q 6 H PRN		
A&D Ointment, Desitin, Vaseline	Skin irritation	1 Topical application to site	Q 1 H PRN		
Bacitracin ointment		1 Topical application to site			
Cough drops	Coughing	1 cough drop	Q 2 H PRN		
Eucerin/other unscented hand /body lotion	Apply to dry, itchy skin	1 Topical application to site	Q 2-4 H PRN		
Ibuprofen (100mg/5ml)	Headache, Pain or Fever>101° F	_____ mg po	Q 6-8 H PRN		
Ibuprofen (200 mg Tablets)	Headache, Pain or Fever>101° F	_____ mg po	Q 6-8 H PRN		
Tums	Heartburn, indigestion	2-4 chewable tablets	Q 4 H PRN		

To be completed by Health Care Provider:
I authorize the OTC medications initialed above to be administered to this student

Name/Title of Licensed Prescriber: (please print)	License #:	Date:
Signature:		Initials:
Office Address:		Phone:
Diagnosis:		

To be completed by Parent/Legal Guardian:

Name: (please print)	Date:
Signature:	Initials:
Home Phone:	Cell Phone:

Adopted: 3/30/2017
Reviewed: 8/21/2024