The Windward School

PERMISSION TO RECEIVE OVER-THE-COUNTER MEDICATION

STUDENT NAME: _____ **Date of Birth:** _____

SIGNATURES OF **BOTH** THE **PHYSICIAN** AND THE **PARENT/GUARDIAN** ARE REQUIRED IN ORDER FOR THE SCHOOL NURSE TO DISPENSE MEDICATION OF ANY KIND INCLUDING THOSE BELOW:

OTC MEDICATION	DOSE	FREQUENCY	ROUTE
Acetaminophen (Tylenol) (pain, fever)			
Ibuprofen (Advil/ Motrin) (pain, fever)			
Diphenhydramine (Benadryl) (allergic reaction/allergy)			
Antacid (Tums) (abdominal discomfort)			
Cough Drops/ Throat Lozenges (cough, sore throat)			
Antibiotic Ointment (skin lesions)			
Other -			

ADDITIONAL COMMENTS:

PHYSICIAN

Physician/Practitioner Signature: _____ **Phone** _____

Name/Address_____ **Fax** _____
(*May use stamp below*)

PARENT/GUARDIAN

I give permission for medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____ **Date:** _____