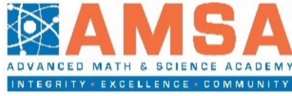

OFFICE OF SCHOOL NURSE
201 Forest Street, Marlborough, MA 01752
Phone 508 597-2475/2473 – Medical FAX 508 -597 2494

PARENTAL PERMISSION FOR OTC STANDING MEDICATION ORDERS 2022-23

Student Name: ____ **Grade:** 6 7 8 9 10 11 12

Dear Parent/Guardian;

There are times when your child may come to the Nurse's Office with a headache, upset stomach, cold symptoms, or pain from orthodontia, sports injuries, or menstrual cramps. With written permission from a parent or guardian, your child may receive **up to three (3) doses each school year** of over-the-counter medication to relieve their symptoms and allow them to have a successful school day – without you having to get an order from their primary care physician! **However, these medications are intended for very infrequent use. Any child needing more than 3 doses per year is required to get a physician's order.**

Our school physician, Angela D. Hunt, MD of Town Center Pediatrics, has provided standing orders and protocols for the medications listed below. If you would like your child to receive any of these medications at school, please indicate your preferences below and sign your consent. No medication will be dispensed if your child exhibits a fever, or signs of an illness or condition that warrants physician assessment or dismissal from school. Other pain-relief methods such as ice/hot packs, relaxation and breathing techniques, and hydration/snack, will be used before medication is offered.

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Allergies: ____

Medical conditions: ____

List ALL medications/herbs your child takes daily or occasionally: ______________________________

My child has permission to receive the medication(s) checked below. I understand this medication will be given only after the nurse has made an assessment and determines it is appropriate and necessary;

○ **Ibuprofen, 400 mg**.
for pain relief

○ **Acetaminophen, 650 mg**.
for pain relief

○ **Throat lozenge**
for sore throat/cough

○ **Caladryl**
for itching rash

○ **Lip Balm**
for dry lips

○ **Covid Testing**
I authorize collection and testing of a sample from my student for Covid-19 at school for a rapid individual testing if my student is symptomatic. Testing will continue until school testing tests run out.

Please call me every time my child receives a dose of medication ○ No ○ Yes

Please call me every time my child is tested for Covid ○ No ○ Yes

Daytime phone number________________________________ Daytime e-mail: ____________________________

Parent/Guardian Signature ____Date____________