

Mount Olive High School

COREY ROAD, FLANDERS, NEW JERSEY 07836

Telephone Number (973) 927-2208 Ext. 7480

Nurse Fax Number (973) 927-2210

Over-The-Counter Medication Administration Form

Dear Parent/Guardian,

In collaboration with our school physician and state recommendations, over-the-counter medications will only be administered during school with parental permission. Each student is required to return this form to the health office, with appropriate signature, in order to be medicated in school. Please be advised this form is only for the medications listed and is to be updated annually.

This is for 9th-12th grades only.

Student's Name: _____ School Year _____

I request that the school nurse administer the following medications as prescribed below:

Please initial all medications that you are giving permission for your child to take.

	Acetaminophen (Tylenol) 325mg (2 tablets) every 4 hours as needed for pain
	Ibuprofen (Advil) 200 mg (2 tablets) every 6 hours as needed for pain
	Antacid (Calcium Carbonate, Tums) 2 chewable tablets once a day as needed for indigestion/stomach ache

I give permission for the school nurse to dispense the above medications to my son/daughter as needed and endorse that my child does not have an allergy to any of the selected medications.

Both printed name and signature is required of parent/guardian in order for form to be valid.

Parent/Guardian (Print Name) _____

Parent/Guardian Signature _____ Date _____