pace
Learning Redefined

2432 Greensburg Pike,
Pittsburgh, PA 15221

Phone 412.244.1900
Fax 412-244-1902

Health Office Phone 412-342-4317
www.paceschool.org

PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS

Effective 2025/2026 School Year

including Extended School Year (ESY) 2026

If your child has any physical complaints such as: headaches, fevers, cuts, toothaches, itchy rashes, bug bites, etc., while they are in school, we will need a written order from a Licensed Prescriber (Physician, Nurse Practitioner, Physicians Assistant or Dentist) and permission from you, the Parent/Legal Guardian, to administer or use any of the following over the counter medications. Pace School will have a supply of the over the counter medications listed below but if the Licensed Prescriber orders any other over the counter medications, it will be your responsibility, the Parent/Legal Guardian or responsible adult, to bring the medication to the Health Office and it must be in the original labeled container with the child's name and date of birth written on it.

THIS SECTION TO BE COMPLETED BY THE LICENSED PRESCRIBER **PLEASE CROSS OUT ANY MEDICATIONS NOT ALLOWED. Additional medications to be administered/used can be written in the space provided.**

STUDENT'S NAME:				**DATE OF BIRTH:**	
MEDICATION & STRENGTH	**DOSE**	**ROUTE OF ADMINISTRATION**	**HOW GIVEN**	**REASON FOR USING THE MEDICATION**	**OTHER INFORMATION**
ACETAMINOPHEN (Tylenol) 325mg (tablet) OR (160 mg/5mL (liquid)		**ORAL**	**Every 4-6 hours as needed**	**Pain, Fever, Headache**	
IBUPROFEN (Motrin/Advil) 200 mg (tablet) OR (100 mg/5mL (liquid)		**ORAL**	**Every 6-8 hours as needed**	**Pain, Fever, Headache**	
BENADRYL 25 mg (caplet) OR 12.5 Ml (liquid)		**ORAL**	**Every 4-6 hours as needed**	**Allergies**	
TUMS 1-2		**ORAL**	**As needed**	**Heartburn, upset stomach**	
Orajel	**N/A**	**TOPICAL**	**As needed**	**Toothache**	
Sting Kill/Calamine Lotion	**TOP**	**TOPICAL**	**As needed**	**Bug bites, rashes, poison ivy**	
Antibiotic Ointment	**N/A**	**TOPICAL**	**As needed**	**Cuts & abrasions**	
Hydrocortisone Cream	**N/A**	**TOPICAL**	**As needed**	**Redness, itching, swelling**	
Burn Gel	**N/A**	**TOPICAL**	**As needed**	**Burns**	
Sunscreen (parent must provide)	**N/A**	**TOPICAL**	**As needed**	**Sun Protection**	

ALLERGIES: Food/Drug/Environmental

_____/____/____ _____ _____

DATE **Signature of Licensed Prescriber** **Printed name of Licensed Prescriber**

ADDRESS: _____ **PHONE:** _____

_____ **FAX:** _____

THIS SECTION TO BE COMPLETED BY THE PARENTS

I give permission for my child to be given or use the above medications during school hours as ordered by the Licensed Prescriber. I give permission to the nurse to contact the Licensed Prescriber, as necessary, regarding the above medication order. I also agree to follow the procedures listed on the back of this form.

Parent/Legal Guardian Signature: _____ Date: ____/____/_____

Student Signature (if 14 years of age or older): _____ Date: ____/____/_____

PACE SCHOOL
MEDICATION ADMINISTRATION PROCEDURES

1. **WRITTEN ORDER – NO** medications, prescription or over the counter, will be given without a written order from a Licensed Prescriber (Physician, Certified Nurse Practitioner, Physicians Assistant or Dentist). Faxes of the completed PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS form will be accepted.

2. **PARENT PERMISSION-** The Parent/Legal Guardian must provide the nurses with written permission before any medications will be given. A two person verbal consent may be obtained by the nurses initially but the Parent/Legal Guardian is still required to sign the PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS form as soon as possible.

3. **PRESCRIPTION MEDICATIONS- ALL** medications **MUST** be in a labeled pharmacy bottle/container/package. Please ask your pharmacist to provide a separate labeled bottle/container/package for each medication. Please ask your pharmacist to place a label on all Epinephrine Auto-Injectors and Asthma Inhalers.

4. **OVER THE COUNTER MEDICATIONS-** Must be in the original labeled container from the manufacturer. Parents/Legal Guardians are to write their child's name and date of birth on the container.

5. **TRANSPORTATION OF MEDICATIONS- ALL** medications (prescription and over the counter) **MUST** be delivered to the Health Office by the Parent/Legal Guardian or responsible adult. **STUDENTS ARE NOT PERMITTED TO CARRY MEDICATIONS TO OR FROM SCHOOL.**

6. **YEARLY OVER THE COUNTER MEDICATION ORDERS-** A new signed PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS form is required every year or whenever there is a change in the dose of the medication during the current school year including the Extended School Year Program.

7. **FAILURE TO FOLLOW THE ABOVE PROCEDURES WILL RESULT IN THE MEDICATION NOT BEING ADMINISTERED AT PACE SCHOOL.**

ORAL AUTHORIZATION – NOT APPLICABLE TO HIV RELATED INFORMATION

I witness that the person understood the nature of this consent and freely gave his/her oral authorization. (Two witnesses are required)

Name of person giving oral authorization: _____

Relationship: _____

Witness #1: _____ Date: _____

Witness #2: _____ Date: _____

The Parent/Legal Guardian was informed that a two person verbal consent may be obtained by the nurses initially to administer medications but the Parent/Legal Guardian is still required to sign the PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS form as soon as possible.