



Mendham Township Elementary School

18 West Main Street, Brookside, NJ 07926

973-543-7107

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS (OTC) DURING SCHOOL HOURS

Student Name: _____ Date of birth: _____ Grade: _____

Parent/Guardian Name: _____

Home Address: _____

Parent/Guardian Phone: Home: _____ Cell: _____ Work: _____

I request that my child be administered the following OTC medication(s) by the school nurse if needed throughout the current school year as directed by my child's medical provider below. **Medical authorization forms are effective for the 365 days unless otherwise noted by MD below.**

Parent/Guardian Signature: _____ Date: _____

This section for completion by Licensed Medical Provider:

The following OTC medications will be stocked in the school health office: Acetaminophen liquid (160mg/5ml), Acetaminophen tabs (325 mg/tab), Ibuprofen liquid (100mg/5ml), Ibuprofen tabs (200mg/tab), Diphenhydramine HCl/Benadryl liquid (12.5mg/5ml), Diphenhydramine HCl/Benadryl tabs (25mg/tab).

Medication: _____ Route: _____ Dosage: _____

Frequency: _____ Reason for use/signs & symptoms: _____

List side effects and/or contraindications: _____

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Frequency: _____ Reason for use/signs & symptoms: _____

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List side effects and/or contraindications: _____

Topical: Calamine anti-itch lotion _____ Medcaine _____ Neosporin _____ Hydrocortisone 1% cream _____

Provider's Signature: _____ Date: _____ (STAMP)

Discontinue Date: End of _____ school year



Every Student, Every Day

<http://www.mendhamtpw.org>