



## ORCHARD PARK CENTRAL SCHOOL DISTRICT OVER THE COUNTER MEDICATION ORDER FORM

Child's Name:	DOB:	Allergies:
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Medication	Indications for use and conditions under which medication should be administered. <i>Please add indications if needed</i>	Dosage and Route of Medication	Frequency and/or Time	Health Care Provider Consent <i>Please Initial</i>	Parent/Guardian Consent <i>Please Initial</i>
Acetaminophen Elixir (160mg/5ml)	Headache, pain or fever >100.4° F	_____ mg po			
Acetaminophen tablets (325mg)	Headache, pain or fever >100.4° F	_____ mg po			
Petroleum Jelly	Skin irritation	1 Topical application to site			
Unscented hand/body lotion: <i>Cetaphil Unscented Hypoallergenic</i>	Apply to dry, itchy skin	1 Topical application to site			
Ibuprofen Elixir (100mg/5ml)	Headache, Pain or Fever >100.41° F	_____ mg po			
Ibuprofen Tablet (200 mg)	Headache, Pain or Fever >100.4° F	_____ mg po			
Topical Anti-Itch: <i>Caladryl Clear</i>	Apply to itchy skin	1 Topical application to site			
Cough Drops: <i>Goodsense Brand</i>	Cough, Sore Throat	Dissolve one drop PO			
Saline Eye Wash	Eye irritation	1 topical irrigation of eyes			
Other (supplied by parent/guardian):					

**To be completed by Health Care Provider:**

*I authorize the medications I have initialed above to be administered to this child.*

Name/Title of Licensed Prescriber: (please print)	License #:	Date:
Signature:		Initials:
Office Address:		Phone:

**To be completed by Parent/Guardian:**

Name: (please print)	Date:	
Signature:	Initials:	
<input type="checkbox"/> I give the school permission to use their stock OTC medication listed on this form		Cell Phone: