



OVER-THE-COUNTER (OTC) MEDICATION AUTHORIZATION 2026-2027

Student Name: _____ Date of Birth: _____ Grade: _____

OTC medications are administered per package directions based on a child's weight unless other written directives are provided by a licensed primary care provider.

Over-the-Counter Medication dispensed per package directions	Indications	Yes	No	Indicate specific dose if different from package instructions
Ibuprofen (Advil) or generic	Pain reliever/fever reducer			
Acetaminophen (Tylenol) or generic	Pain reliever/fever reducer			
Antihistamine (Benadryl, Claritin, Zyrtec)	Episodic seasonal allergy discomfort			
Other OTC medication Specify: _____	Specify: _____			

I hereby request and authorize National Presbyterian School personnel to administer medication as directed by the primary care provider to my child named above. I agree to release, indemnify, and hold harmless National Presbyterian School and its employees from lawsuit, claim, demand, or action against them for administering the above medication/s to this student, as directed by the primary care practitioner.

Primary Care Practitioner Signature

Date

Parent/Guardian Signature

Date