



# WATCHUNG HILLS REGIONAL HIGH SCHOOL

ELIZABETH C. JEWETT, PhD  
SUPERINTENDENT

WILLIAM J. SCHOLTS, CPA, PSA  
BUSINESS ADMINISTRATOR

WILLIAM J. LIBRERA, EDD  
PRINCIPAL

## SCHOOL MEDICATION AUTHORIZATION FORM – OTC MEDICATIONS

School: Watchung Hills Regional High School School Year: \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Provider Authorization

Check all medications approved and complete dosage, frequency, and indications. Only medications stocked by the school are listed below.

**Acetaminophen** ☐ Dose: \_\_\_\_\_ mg Freq: q \_\_\_\_\_ hrs Max: \_\_\_\_\_ mg/24 hr

Indications: ☐ Headache ☐ Fever ☐ Pain ☐ Menstrual cramps ☐ General discomfort

**Ibuprofen** ☐ Dose: \_\_\_\_\_ mg Freq: q \_\_\_\_\_ hrs Max: \_\_\_\_\_ mg/24 hr

Indications: ☐ Headache ☐ Pain ☐ Menstrual cramps ☐ Injury pain ☐ General discomfort

**Tums / Calcium Carbonate** ☐ Dose: \_\_\_\_\_ mg Freq: q \_\_\_\_\_ hrs Max: \_\_\_\_\_ mg/24 hr

Indications: ☐ Heartburn ☐ Upset stomach

**Non-medicated cough drops** (no menthol, benzocaine, or active drug ingredients) ☐

Dose: 1 lozenge Freq: PRN Max: \_\_\_\_\_ per school day

Indications: ☐ Cough ☐ Sore throat

**Diphenhydramine (Benadryl®)** – allergic reaction only ☐ Dose: \_\_\_\_\_ mg Freq: q \_\_\_\_\_ hrs Max: \_\_\_\_\_ mg/24 hr

Indications: ☐ Allergic reaction (hives, itching, mild allergic symptoms only)

**Important Notice:** Diphenhydramine may cause drowsiness or sedation. If side effects interfere with the student's ability to safely remain in school, the parent/guardian may be contacted for early dismissal at the discretion of the school nurse.

Additional Orders: \_\_\_\_\_

### Authorization by Parent/Guardian:

I hereby give permission for my child to receive medication at school as prescribed above by my child's physician. I understand the ultimate responsibility for administration of the medication is mine and do hereby release, discharge and hold harmless WATCHUNG HILLS REGIONAL HIGH SCHOOL, its agents and employees from any and all liability and claim whatsoever for the administration of the above medication pursuant to these directions. I also give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and treatment.

**Provider Information:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICIAN OFFICE STAMP REQUIRED