ST. MARTIN'S IN-THE-FIELD EPISCOPAL SCHOOL

OVER-THE-COUNTER MEDICATION AUTHORIZATION FORM

NO over-the-counter medication will be given without physician's signature or office stamp.

MUST BE COMPLETED AND SIGNED BY A PHYSICIAN

Student Name: _____ DOB:_____/_____/_____ Grade:_____ School year:_____

Effective dates: ☐ Entire school year **OR** Begin (date) _____ to terminate (date):_____

This request must be signed by a parent or guardian and the health care provider to authorize giving over-the-counter medication (as indicated below) during school hours.

I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I authorize St. Martin's in-the-Field Episcopal School personnel to administer the medication as indicated below: (please check all that apply):

_____ ***Acetaminophen (Tylenol Junior Strength)*/Grades 1-4** —320/480 mg every 4 hours for students complaints of pain, headache, cramps, earache or fever above 100.6

OR

_____ ***Acetaminophen (Tylenol)*** **/Grades 5-8**—320/480 mg every 4 hours for students complaints of pain, headache, cramps, earache or fever above 100.6

_____ **Ibuprofen (Advil /Motrin)** 200 mg every 6 hours for student complaints of pain, headache, cramps, earache or fever above 100.6

_____ **Benadryl** - 1 to 2 tsps. every 4 to 6 hours for students complaining of symptoms of allergic reactions including hives, itching and swelling

_____ **Topical antibiotic cream / ointment (Neosporin)** for cuts, scrapes, and/or abrasions

_____ **Saline** for eye irritation / contact lenses

_____ **Topical Benadryl gel / lotion** for insect bites and/or pruritic allergic skin reactions

_____ **Cough drops** for student complaints of sore throat / excessive coughing

____ I DO NOT WISH MY CHILD TO RECEIVE ANY OVER-THE-COUNTER MEDICATION

(Please note: For students in grade 1 – 4 , parents will be notified before any medication is given)

Possible adverse effects: _____ Possible drug interactions: _____

Additional instructions: _____ Student allergies: _____

Physician Name (printed): _____ Date: _____ Physician phone: _____

Physician signature _____ The first dose of this medication has been given without problems: _____

(Physician or Parent initials)

Signature of Parent / Guardian: _____ Date: _____ Relationship to student: _____

Phone number: (H) _____ (W) _____ Other: _____

Below line is for school use only - must be initialed by authorized personnel each time medication is administered.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Codes :

A = Acetaminophen **B** = Benadryl (oral) **CD** = cough drop **N** = Neosporin (topical)

AJ = Acetaminophen Jr. **BT** = Benadryl (topical) **I** = Ibuprofen **S** = Saline (eye drops)

School Nurse / Delegate Signature: _____ Initials: _____

Signature of persons authorized to render service:

_____ Initials: _____

_____ Initials: _____

_____ Initials: _____