EAST AMWELL TOWNSHIP SCHOOL

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PERMISSION FOR (OTC) OVER THE COUNTER MEDICATION TO BE ADMINISTERED BY THE SCHOOL NURSE FOR THE _____ SCHOOL YEAR

PARENTAL PERMISSION:

I REQUEST THAT MY CHILD_______________________________________ BE ADMINISTERED THE FOLLOWING OTC MEDICATION BY THE SCHOOL NURSE:

MEDICATION: **Tylenol**_______________________________________
Advil (Ibuprofen)_______________________________________
Benadryl_______________________________________
Other (specify)_______________________________________

DOSE: Per Weight (enter weight)____________

FREQUENCY: As directed

PARENTAL NOTIFICATION BEFORE ADMINISTRATION: ___YES or ___NO
I assume full responsibility for the administration of the above medication(s) and will notify the school nurse of any changes in my child's health status. I understand I must supply the above medication(s) in their original container(s).
PARENT/GUARDIAN SIGNATURE__________________________ DATE_____

PHYSICIAN PERMISSION (MANDATORY):

I hereby authorize the school nurse to administer the above OTC medication(s), according to the above directions.

____
M.D. Name (Please stamp)

____
M.D. Signature

____
Address/Phone

____
Date

Please note that student must provide his/her own supply of medicine, And the medicine must be sent to school in it's original container.