EAST AMWELL TOWNSHIP SCHOOL

National Blue Ribbon School of Excellence

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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 containers(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 its original container