

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 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.**