**St Margaret's School**
**201 Roxboro Rd**
**Mattydale, NY 13211**
**315-455-5791**
**FAX 315-455-1250**

# OVER THE COUNTER (OTC) MEDICATIONS AUTHORIZATION FORM (MUST BE SIGNED BY THE LICENSED HEALTH CARE PROVIDER AND THE PARENT/GUARDIAN)

| Student's Last Name | First Name | Grade | Date of Birth |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

The above student has permission to receive the following OTC medications during the _____ school year as needed.

**Please check all items below that you want this student to receive. Please write the dosages in the space provided.**

☐ **Acetaminophen (Tylenol)** every 4 hours as needed per package directions for headache, pain or fever. **Please mark correct dosage!**

**Regular strength** (325 mg. per tablet)_____mg.
**Junior strength**_____mg.
**Children's Chewable**_____mg.
**Children's Liquid (elixir or suspension)**_____mg.

☐ **Ibuprofen (Motrin)** _____ mg. May use per package instructions every 6 hours as needed for headache, muscle aches, pain or fever. **Ibuprofen must be provided by the parent/guardian.**

☐ **Bacitracin Antibiotic Ointment** may be used as needed to help prevent infection in minor cuts, scrapes and burns after cleansing with soap and water.

☐ **Cough Drops** – For cough or minor sore throat **(Cough drops must be provided by parent and labeled with student's name and kept in the nurses office during the school day**)

☐ **Calamine Lotion** may be applied to bug bites, dry poison ivy/oak lesions, dry eczema, hives and dry itchy red rashes after soap and water.

_____

**Parent/Guardian Signature** **Date**

_____

**Licensed Health Care Provider Signature** **Date**