

**MAIN STREET SCHOOL OF PERFORMING ARTS
HEALTH SERVICES**

Authorization for Administration of Over the Counter Medication at School

Parents/guardians asking school staff to give medications to their child must provide (written) permission from themselves and the health care provider every school year.

Student: _____ BD: _____ Grade: _____

School: _____ School year: _____

Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
1. Pain	Ibuprofen	400-600 mg	every 6 hours as needed	po	Abdominal discomfort
2. Pain	Tylenol	650-1000 mg	every 4-6 hours as needed	po	none
3. Stomach Upset	Antacid Tablets				
4. Sore Throat/Cough	Cough Drops				

Start date: _____ Stop date: _____
(Authorization expires at the end of the school year or following the summer school session)

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours.
2. I will notify the school of any change in the medication(s), (i.e. dosage change, medication is stopped, etc.)
3. I give permission for the school nurse to communicate as needed with school staff about my child's health condition(s) and the action of the medication(s).
4. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).

Parent/Guardian signature

Date

Relationship to Student