CONCORDIA PREPARATORY SCHOOL

Over-the-counter Medication Authorization Form

School Year: 2017/18 Grade:_______

Student Name: ____ Date of Birth ___/___/___

Allergies: ____

Current Medications: ____

_______ I DO NOT WANT ANY OVER-THE-COUNTER MEDICATIONS GIVEN TO MY CHILD AT SCHOOL. ____ **Date:** ______________

Parent/Guardian Signature

Over-The-Counter Medication Authorization

Type of Medication* * The generic equivalent may be used in place of brand name.	**Description of symptoms for which medication** should be administered.** ** All medication will be administered according to original package instructions.	**This student is authorized to be administered this Medication.** (Please Circle)	
Acetaminophen (i.e. Tylenol)	Headache, muscle aches, pain, menstrual cramps, fever	Yes	No
Ibuprofen (i.e. Motrin, Advil)	Headache, muscle aches, pain, menstrual cramps, fever	Yes	No
Cough drops / Sore throat lozenges	Coughs and minor sore throat pain	Yes	No
Calamine Lotion	Minor skin irritation	Yes	No
Antibiotic Ointment	Cuts, scrapes and /or abrasions	Yes	No
Hydrocortisone 1%	Rash, inflammation, insect bites, itch	Yes	No

Physician's Comments: ____

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Physician Signature:____ Date: ___________

Physician Printed Name: ______________________________Phone Number:__________________

Note: NO Over-the-counter medication will be given without a physician's signature.

I hereby authorize the above named student to receive any (OTC) medication indicated above from the School Nurse. I understand the generic equivalent of medications may be used. I understand that the medication will be administered as directed on the original manufacturer container unless otherwise noted by the physician. A physician's signature as well as a parent's (or legal guardian) signature are required for these medications to be given.

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Parent/Guardian Signature **Date:**