Physician Authorization for Administration of Medication(s)

Student Name_____ DOB__/__/__ Grade/Class_____

Over the counter medication can be given at school with the consent of a parent and a **required physician's signature** for the dispensing of the following common OTC medications. Each medication will be administered as directed by the physician's order (**WITH DOSING AMOUNTS & FREQUENCY**). Please circle yes of no if your child is allowed to have the medication/treatment listed below administered at school.

Acetaminophen for pain **DOSE & Frequency:**	Yes	No	Ibuprofen for pain **DOSE and Frequency:**	Yes	No
Petroleum Jelly for chapped lips, abrasions	Yes	No	Hydrocortisone cream 1% for itching	Yes	No
Heating pad for aches and/or menstrual cramps	Yes	No	Antacid for GI upset (Tums)	Yes	No
Baking soda paste for stings and splinters	Yes	No	Hard Candy for sore throat	Yes	No

****Please note**** If the child has an elevated temperature (≥100.0 ° F), vomiting, diarrhea, rash, green respiratory drainage, green drainage from one or both eyes &/or lice, a parent or guardian will be contacted and will need to make arrangements to pick their child up immediately. Students may not return until they have been fever/symptom free for 24 hours (without medication). If necessary, the school nurse and/or principal may ask for a written statement from a licensed physician stating it is safe for the student to return.

List all allergies, drug reactions, and health conditions:

_____

_____

_____

List all medications taken at home on a regular basis:

_____

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We understand that under the provision of Florida Statute 232.46 school personnel cannot be held liable for reactions or side effects from the administration of the above medication(s). We also grant permission to contact myself and/or the physician if there are questions or concerns about medications. I have read the "Guidelines for Administrations of Medication".

Parent/Guardian Signature_____ **Physician Stamp:**

Daytime Contact Number_____

Physician's Signature_____

Physician's Phone Number_____

Date_____