



PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION  
OF OVER-THE-COUNTER MEDICATIONS

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Allergies: \_\_\_\_\_ Other Medications: \_\_\_\_\_

**ADVIL 200mg** \_\_\_\_  
Dosage: 1 tab \_\_\_\_ 2 tabs \_\_\_\_  
p.o. every 6 hours as needed

**Reason:** Headache, fever, muscle aches, menstrual cramps

**TYLENOL 325 mg** \_\_\_\_  
Dosage: 1 tab \_\_\_\_ 2 tabs \_\_\_\_  
p.o. every 4 hours as needed

**Reason:** Headache, fever

**BENADRYL 25 mg** \_\_\_\_  
Dosage: 1 tab \_\_\_\_ 2 tabs \_\_\_\_  
p.o. every 4 hours as needed

**Reason:** Allergy symptoms

**THROAT LOZENGES**  
Dosage: 1 lozenge every \_\_\_\_ hour(s)

**Reason:** Sore throat, dry cough

**ANTACID**  
Dosage: 1 tab \_\_\_\_ 2 tabs \_\_\_\_

**Reason:** Relief of heartburn or upset stomach

**OTHER OTC MEDICATION:**

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Dosage: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATION SHALL BE ADMINISTERED FROM APRIL – JUNE**

**PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL**  
I give the school permission to administer the above medications during school hours as needed.

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# From the Health Office

## Eagle Hill School

### PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Condition for which the drug is being administered \_\_\_\_\_

Drug \_\_\_\_\_

Dose \_\_\_\_\_

Method of Administration \_\_\_\_\_

Time of Administration \_\_\_\_\_

Medication shall be administered from \_\_\_\_\_ to \_\_\_\_\_

Relevant side effects to be observed, if any \_\_\_\_\_

If there are side effects, plan for management \_\_\_\_\_

Is this a controlled drug? \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

### PARENT AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

I hereby request that the medication ordered by the physician for my child be administered by school personnel. I understand that I must supply the school with the medication in the original pharmacy bottle or the original over-the-counter container. I understand that medication must be delivered to school by an adult and that any medication not picked up one week beyond the close of school will be destroyed.

Parent's Signature \_\_\_\_\_