

WATERTOWN PUBLIC SCHOOLS

PERMISSION FOR (OTC) OVER-THE-COUNTER MEDICATION

PLEASE NOTE: *Permission must be updated each school year!*

PHYSICIAN'S ORDER

Students Name: _____ DOB: _____

<u>Medication:</u> (Please ✓)	<u>Dosage</u>	<u>Amount</u>	<u>Frequency</u>	<u>Reason</u>
Tylenol (acetaminophen)	_____	_____	_____	_____
Advil (ibuprofen)	_____	_____	_____	_____
Tums	_____	_____	_____	_____
Other:	_____			

I hereby authorize only the school nurse to administer the above OTC medication.

Please stamp M.D. Name (*required*) M.D. _____ Signature (*required*) _____

Address/Phone Number _____ Date _____

PARENT CONSENT

My child _____ Grade: _____

Has my permission to receive the above OTC medication by the school nurse.

Please check one: My child has had the above medication before:

Yes _____ No _____

If no, medication will not be administered for the first time at school.

Signature of Parent/Guardian (*required*) _____ Date _____

ELEMENTARY PARENT NOTIFICATION: (check one)

____ Call before administering, ____ Leave a message, ____ No need to call

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE

Katherine Taverna RN, Office # 617-923-6475 Fax # 617 924-4191

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