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**: _____

Medication: (Please ✓)	**Dosage**	**Amount**	**Frequency**	**Reason**
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