The Marshall School

Over-the-Counter Medication Authorization Form

This form is to be completed annually by a parent/guardian ONLY. Please notify the school of any changes in this information throughout the school year.

Student's Name: ____Preferred Name ________________________________

Date of Birth _________/______/______ Age _________ Sex _________ Height ______________ Weight ______________

List any ***medication allergies*** with type and severity of reaction ____

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Daily Medication(s) – *Please list anything taken routinely, to include vitamins and over-the-counter medications*

Medication ______________________________ Dose ________ Frequency __________ Given for __________________

Medication ______________________________ Dose ________ Frequency __________ Given for __________________

Medication ______________________________ Dose ________ Frequency __________ Given for __________________

Medication ______________________________ Dose ________ Frequency __________ Given for __________________

Medication ______________________________ Dose ________ Frequency __________ Given for __________________

Medication	Initial, if permitted	Symptoms that it will be administered for
Acetaminophen, tablets, 325mg		Pain or temperature >100.5F
Acetaminophen, liquid, 160mg/5mL		Pain or temperature >100.5F
Ibuprofen, tablets, 200mg		Pain or temperature >100.5F
Ibuprofen, liquid, 100mg/5mL		Pain or temperature >100.5F
Diphenhydramine HCl, liquid		Severe allergic reactions (*emergency only*)
Diphenhydramine HCl, tablet		Severe allergic reactions (*emergency only*)
Diphenhydramine HCl, topical cream		Hives (*emergency only*)
Hydrocortisone 1%, topical cream		Itching, insect bites
Antibiotic Ointment, topical		Cuts, scrapes
Cough Drops, Vitamin C drops		Coughing
Throat Lozenges (only >12)		Sore Throat
Tums (only >12)		Heartburn, stomach hurts

I authorized staff at The Marshall School to administer the medication as directed by the manufacturer, under the supervision of the nurse or authorized staff member. I certify that I have the legal authority to consent to medical treatment for the child named above, including the administration of medication.

Parent/Guardian Name (*Please Print*)____ Date______________________

Parent Signature ____