



## *Over the Counter Medication Order*

*Dear Parent(s) / Guardian,*

*By law students cannot be given any over the counter medications or treatments unless there is a written order from your child's health care provider and written parental permission to administer these medications.*

*Having these orders on hand allows us to treat a child's headache, aches and pains, stomach ache, allergy symptoms and minor injuries with the goal of keeping our students in class.*

*ALL medications are kept in the Health Office.*

*Please have your health care provider initial the medications appropriate for your child.*

*Please attach any additional Over the Counter Medication Orders to this document.*

*The completed form can be sent to school with your child on the first day of school, or faxed top me at 518-437-8677.*

*Thank you.*

*Sincerely,*

*Kimberly Whelan BSN/RN*

*TVHS School nurse*



TV 132 prn

## Over the Counter Medication Order

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. \_\_\_\_\_ **Acetaminophen 650 mg** po Q 4-6 hours prn Pain or Fever  
❖ (Not to exceed 4,000mg/24 hour period)
2. \_\_\_\_\_ **Ibuprofen 200-400mg** po Q 4-6 hours prn for pain relief or fever  
❖ (Not to exceed 1200mg / 24 hours unless specified by MD)
3. \_\_\_\_\_ **Benadryl 25mg** po Q 6-8 hours prn for relief of allergy symptoms  
❖ (Not to exceed 300mg per 24 hour period)
4. \_\_\_\_\_ **Antacid Tablets** (Regular Strength) chew 2-4 tab as symptoms occur  
❖ (Not to exceed more than 15 tabs per 24 hour period)
5. \_\_\_\_\_ **Antiseptic Solution** prn
6. \_\_\_\_\_ **Bacitracin / Neosporin Ointment** prn
7. \_\_\_\_\_ **Caladryl / Calamine Lotion** prn for relief of itching skin

Date \_\_\_\_\_ **Provider's Signature** \_\_\_\_\_ Tel. # \_\_\_\_\_

Date \_\_\_\_\_ **Parent's Signature** \_\_\_\_\_ Tel. # \_\_\_\_\_