ST ANN SCHOOL, LAWRENCEVILLE, NEW JERSEY 08638 - HEALTH SERVICES

Student: _____ D.O.B.: _____

School Year: September to June

MEDICATION ADMINISTRATION PERMISSION - P.R.N. (as needed/ over-the-counter OTC)

- All medication doses will be **given as per the directions on the box/bottle/package provided based on age, recommended frequency, and weight of your child** unless otherwise prescribed/documented and initialed below by your Physician.
- Medication must be given to the School Nurse in **OTC original labeled packaging**.
- Medication shall be administered by the School Nurse only upon **signed order of the prescribing physician and by request of the parent as signed/checked below**.

SORE THROAT / COUGH / ANTACIDS / HIVES

☐ Cough drops (e.g. Halls) _____ ☐ Sore Throat Spray (e.g. Chlorseptic)_____

☐ Antacids (e.g. Tums) _____ ☐ Allergic Reaction/Hives (e.g. Benadryl)_____

PAIN (Headache, Menstrual cramps, Muscle strains etc.) or FEVER (102°F or higher)

☐ Tylenol _____ ☐ Advil _____

☐ Ibuprofen _____ ☐ Orajel_____

☐ Pain relieving gels (e.g. Icy-hot/Biofreeze)_____ ☐ **Other**_____

EYE DISCOMFORT (Seasonal allergies)

☐ Eye drops (e.g. Visine) _____ ☐ Contact Lens solution _____

PARENT PERMISSION

☐ **I hereby give permission for the school nurse to administer medication I have provided for use, to my child as directed by the physician.**

☐ I wish to be called before administration of any oral medications to my child: **Phone #**.....

..... Signature of Parent/Guardian ..... Print Name

PHYSICIAN PERMISSION

☐ I hereby give permission to the school nurse to administer the medication/s as checked by the parent above for p.r.n. treatment. Doses will be **given as per the directions on the original OTC container provided, based on age, recommended frequency, and weight of the child unless otherwise prescribed and initialed above by physician.**

Signature of Physician

..... & ADDRESS STAMP