

FAMILY NAME: _____

Torah School of Greater Washington

2010 Linden Lane Silver Spring, MD 20910

(301) 962-8003

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS 2018-2019

As required by the State of Maryland, TSGW will **ONLY** administer over the counter medication to a student with **written consent of BOTH the parents and the physician. No over-the-counter medication will be administered unless this form is on file.**

____ I authorize the Nurse/ Medication Technician to use her discretion to give my child any of the initialed medications noted below.

____ I wish to be called before the Nurse/ Medication Technician dispenses any medication.

____ I do not want my child to receive any medication at school.

Student name _____ Grade _____ Weight _____ lbs.

PARENT SIGNATURE _____ Date _____

Physician: Please Initial Next To Those You Authorize Your Patient To Receive:

ACETAMINOPHEN:

Children/Jr. (liquid or chewable): Age/weight appropriate dose as needed every 4-6 hours _____ **or**
Adult Strength (325 mg/ 1 tablet) Age/weight appropriate dose as needed every 4-6 hours _____ **or**
Extra Strength (500 mg/ 1 tablet) Age/weight appropriate dose as needed every 4-6 hours _____

IBUPROFEN:

Junior strength - (100 mg/ml) Age/weight appropriate dose as needed every 6-8 hours _____ **or**
Adult strength - (200 mg/tablet) Age/weight appropriate dose as needed every 6-8 hours _____

BENADRYL (diphenhydramine) for children ages 6+: (12.5 mg) _____ (25mg) _____

CLARITIN (loratadine): (5 mg) _____ (10mg) _____

BENADRYL CREAM/SPRAY _____ ANTIBIOTIC OINTMENT _____

CHEWABLE ANTACID (TUMS) _____ THROAT LOZENGE _____

FOR PHYSICIAN: The above listed student may receive the medications initialed above.

PHYSICIAN SIGNATURE Date

Physician name or stamp