FAMILY NAME: _____

Torah School of Greater Washington

2010 Linden Lane Silver Spring, MD 20910
(301) 962-8003

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS
2019-2020

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