FAMILY NAME: ______________________________

Torah School of Greater Washington

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

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 can 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 or Other Children's Allergy Medication _____

BENADRYL CREAM/SPRAY _____ **ANTIBIOTIC OINTMENT** ____
CHEWABLE ANTACID (TUMS) _____ **COUGH DROPS** ____ **HYDROCORTISONE CREAM** ____

MEDICATION ALLERGIES? ___Yes ___No If yes, please list: ____________________

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

____
PHYSICIAN SIGNATURE Date

____
Physician name or stamp