Newton Public Schools

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OVER-THE-COUNTER MEDICATION ADMINISTRATION FORM

Dear Parent/Guardian,

If your physician decides it is necessary for your son/daughter to receive **over-the-counter medication** during the school day, the following procedures must be followed. **This form must be completed by his/her physician and signed by the parent/guardian**. This is only for the OTC medications listed below. If your son/daughter requires medication other than these please have your physician complete the Administration of Medication form. **The dosage/frequency must be completed by the physician. This form will remain in effect for the entire school year.**

Physician's Instructions for Over-the-Counter Medication in School

Student's Name: _____

Grade: _____

I request that the school nurse administer the following medication as prescribed below:

_____ Acetaminophen _____
Dosage / Frequency

_____ Ibuprofen _____
Dosage / Frequency

_____ Antacid _____
Dosage / Frequency

Physician's Stamp

Physician's Signature _____ Date _____

I give permission for the school nurse to dispense the above prescribed medication to my son/daughter.

Parent/Guardian Signature _____ Date_____