Mount Pleasant Cottage School
Union Free School District
Over the Counter Medication Authorization

Student Name: ______________________________ DOB: ______________________

______ I do **not** give permission for Non-Aspirin medication to be administered at the school.

Parent/Guardian Signature ______________________ Date ____________

To Be Completed By Health Care Provider

Drug Name	Dosage	Frequency	Route	Indication	Possible side effects	Health Provider order
Acetaminophen			P.O.	Discomfort or Fever		Yes No
Ibuprofen			P.O.	Discomfort or Fever		Yes No
Benadryl			P.O.	Allergic reaction		Yes No
Menthol lozenge	7.6mg		P.O.	Cough/Throat discomfort		Yes No
Antacid			P.O.	Upset stomach		Yes No
Vicks VapoRub			Topical	Nasal congestion		Yes No
Orajel			Topical	Dental discomfort		Yes No
Caladryl			Topical	Allergic reaction		Yes No
Bacitracin			Topical	Prevent infection		Yes No
Hydrocortisone			Topical	Allergic reaction		Yes No
Biofreeze			Topical	Muscular discomfort		Yes No
Self-Direct						Yes No
						Yes No
						Yes No

Prescriber's Signature: ____________________ Date: ________ Please print ______________
Phone number ____________________ Fax Number ____________ E- mail ____________________
I/We request designated school personnel to administer the medication as prescribed by the above prescriber. * I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the. *I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA. *I/We authorize self-directed medication administration.

Parent/ Guardian Signature ______________________ Date __________________________

Please send medication in a small container in original over the counter bottle