Phone: (508) 622-0425 Fax:

Health Services

Over the counter Medications
Grades 6-12

Student____Grade___ Date of birth______________

Name of Parent/ Guardian______________________________

Home Phone_______________ Work________________ Emergency_______________

My son/daughter has the following allergies: ____________________________________

Please list any medications your child is currently taking: _________________________

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In consideration thereof, I hereby hold the school or any officer, agent, or servant thereof, harmless of any liability arising out of the administration of said medication to my child.

Consent:

I give permission to have the school nurse administer the following:

Tylenol for pain, fever, Epipen for unknown anaphylaxis, Benadryl by mouth for itching, Hydrocortisone cream for inflammatory rashes, Antibiotic ointment for minor abrasions, Caladryl/Calamine lotion and Cough drops.

Administration: every 4-6 hours as needed

Dosage: according to the recommended dosage on the medication label to my child:

Name: ____________________________________

Licensed Prescriber (School Physician) **Dr. J. Dolan MD**

I will provide the school nurse with a bottle of Tylenol/ Acetaminophen, Benadryl, Hydrocortizone cream or cough drops as needed with its original label and seal intact.

Parent/ Guardian signature: ___________________________________ Date: _______________________

***This form must be renewed in writing every year. This protocol covers only the medications listed.**