Jamesville-DeWitt Central Schools (Elementary Schools)

Over The Counter (OTC) Medications Authorization Form

(Must be signed by the Licensed Healthcare Provider and the Parent/Guardian)

Student's Last Name	First Name	Grade	Date of Birth

The above student has permission to receive the following OTC medications during the _____ school year as needed:

Please check all items you do want this student to receive as needed. PLEASE WRITE IN DOSAGES IN THE SPACES PROVIDED.

☐ **Acetaminophen** by mouth every 4 hours as needed per package directions for headache, pain, or fever. **PLEASE MARK CORRECT DOSAGE!**

Regular strength (325 mg. per tablet) _____ mg.
Junior strength _____ mg.
Children's Chewable_____ mg.
Children's Liquid (Elixer or Suspension) _____ mg.

☐ **Ibuprofen**_____ mg. May use by mouth every 4 to 6 hours as needed per package instructions for headache, muscle aches, pain or fever. **(Ibuprofen must be provided by the parent/guardian in original store container.)**

☐ **Bacitracin Antibiotic Ointment** may be applied to skin as needed to help prevent infection in minor cuts, scrapes, and burns after cleansing with soap and water.

☐ **Calamine Lotion** may be applied to skin for bug bites, dry poison ivy/oak lesions, dry eczema, hives, and dry itchy red rashes after soap and water.

_____
Parent/Guardian Signature **Date**

_____
Licensed Healthcare Provider Signature **Date**

_____
Healthcare Provider Name Printed or Stamped **Phone Number**