Jamestown Area School District

Over the Counter Medications (OTC)

School Year _____

Student: _____Grade/Teacher _____

The above student may have the "**age and weight appropriate dose"** as per label of the following over the counter medication during school hours and at school functions. I realize that only the school nurse or other licensed medical professional will be allowed to administer over the counter and prescription medications while at school and school functions. OTC medications will be provided by the school unless otherwise indicated.

- All over the counter medication must have a **parent guardian initials to be given**.
- This form must also be **signed by your family doctor/health care provider.**

(Parent Initials)			*(Parent Initials)*		
Acetaminophen (Tylenol)_____		**every 4- 6 hours PRN**	**Ibuprofen (Advil) _____**		**every 6-8 Horus PRN**
Generic Benadryl	**_____**	**every 4-6 hours PRN**	**Tums**	**_____**	**1-2 PRN**
Cough Drops	**_____**	**1-2 daily PRN**	*****Cough Syrup**	**_____**	**1 dose**
*****Other: (not provided by school)_____**			**_____**		
*****Other: (not provided by school)_____**			**_____**		

*****Indicates medication is not provided by the school.**

List all known Allergies:

Parent/Guardian signature:_____ Date:_____

Health Care Provider signature:_____ Date : _____

Additional Comments: