WATKINS GLEN CENTRAL SCHOOL DISTRICT
OVER THE COUNTER MEDICATION ORDER

Our health office has the following over the counter medications on hand that we can assist your child with once this form is completed by both the Provider and Parent/Guardian.

We will always call the parent/guardian to let you know that your child is requesting this and to confirm they haven't already had it and confirm the time it can be provided again if they have.

This form must be signed and initialized by your health care provider and parent/guardian.

Student's Name: _____ **DOB:** _____ **Allergies:** _____

Medication	Indications for use and conditions under which medication should be administered. Please add indications if needed	Dosage and Route of Medication	Frequency and/or Time	Health Care Provider Consent (Please Initial)	Parent/ Guardian Consent (Please Initial)
Acetaminophen Elixir (160mg/5ml)	Headache, pain or fever>101° F	_____ mg po			
Acetaminophen tablets (325mg)	Headache, pain or fever>101° F	_____ mg po			
Acetaminophen 160mg Children's Chewable	Headache, pain or fever (101 or greater)	_____mg/po			
Ibuprofen Elixir (100mg/5ml)	Headache, Pain or Fever>101° F	_____ mg po			
Ibuprofen Tablet (200 mg)	Headache, Pain or Fever>101° F	_____ mg po			

To be completed by Health Care Provider: **I authorize the medications I have initialed above to be administered to this student**		
Name/Title of Licensed Prescriber: (please print)	License #:	Date:
Signature:		Initials:
Office Address:		Phone:

To be completed by Parent/Guardian:	
Name: (please print)	Date:
Signature:	Initials:
☐ **I give the school permission to use their stock OTC medication listed on this form**	Cell Phone: