Authorization for Over-the-Counter Medications

All OTC medications must remain in their original container

Child's name	
Physician's name	
Physician's phone number	
Acetaminophen/Tylenol	
Physician's initials _____	Form (pill, liquid, etc.):_____ Dose:_____ May be given every 4-6 hours for headache or general discomfort
Ibuprofen/Motrin	
Physician's initials _____	Form (pill, liquid, etc.):_____ Dose:_____ May be given every 6 hours for headache or general discomfort
Zyrtec	
Physician's initials _____	Form (pill, liquid, etc.):_____ Dose:_____ May be given once at school for allergies.
Calcium Carbonate/Tums	
Physician's initials _____	Dose:_____ May be given once at school for indigestion.

Physician's Signature		*Date*	

Other OTC Medications (must supply your own medication) Medication name: _____	
Physician's initials _____	Dose:_____ May be given _____.

Physician's Signature		*Date*	

Choose one:	☐ I wish to be called before medication is administered *(Parents of students in 3rd grade and younger will always receive a call first.)* ☐ Please administer the medication, then inform me via email *(This option is only available for students in 4th-8th Grade.)*

Parent's Signature		*Date*	

SAINT JOSEPH SCHOOL | 6024 Old Antonia Rd., Imperial, MO 63052
phone: 636-464-9027 | www.stjosephimperial.org
Member of the National Federation of Nonpublic Schools Accrediting Association