

AUTHORIZATION FOR THE ADMINISTRATION OF NON ASPIRIN OR ASPIRIN SUBSTITUTES AND/OR OVER-THE-COUNTER MEDICATION BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations requires a physician's written order and parent's or guardian's authorization for a nurse or in her absence, the principal or her designee to administer non-aspirin or aspirin substitutes or over-the-counter medication to a student **IF NEEDED** during the current year **20__ - 20__**.

PLEASE NOTE: A PROVIDER'S (PHYSICIAN, DENTIST, APRN, OR PA) SIGNATURE IS REQUIRED YEARLY IN ORDER FOR YOUR DAUGHTER TO RECEIVE ANY OF THE BELOW MEDICATION IN SCHOOL.

PROVIDER'S ORDER

Date: _____

Name of Student: _____ Date of Birth: ____/____/____
(Month/Day/Year)

Address: _____

Over the counter medication authorization: I hereby give permission for the above named person to use the following over the counter medications and/or their generic equivalents as directed on the label.

Please mark Yes or No for the following medications or their generic substitutions:

Please circle one

<u>Advil or Motrin (Ibuprofen)</u>	Yes	No	200 mg. / 400 mg. / 600 mg. / 800 mg.
<u>Tylenol (Acetaminophen)</u>	Yes	No	325 mg. / 500 mg. / 700 mg. / 1000 mg
<u>Aleve (Naprosin)</u>	Yes	No	220 mg. / 440 mg.
<u>Midol</u>	Yes	No	Teen Formula
<u>Pamprin</u>	Yes	No	Regular Strength / Extra Strength
<u>Cold or Sinus Medication</u>	Yes	No	(that contains Acetaminophen or Ibuprofen)

<u>Bactine</u>	Yes	No	<u>Hydrocortisone Cream</u>	Yes	No
<u>Bacitracin</u>	Yes	No	<u>Imodium A/D Caplets</u>	Yes	No
<u>Benedryl (oral)</u>	Yes	No	<u>Maalox or Mylanta</u>	Yes	No
<u>Benedryl (topical)</u>	Yes	No	<u>Milk of Magnesia</u>	Yes	No
<u>Ben-Gay or Flex-all</u>	Yes	No	<u>Neosporin Ointment</u>	Yes	No
<u>Caladryl</u>	Yes	No	<u>Pepto Bismol</u>	Yes	No
<u>Chloraseptic Spray</u>	Yes	No	<u>Roloids or Tums</u>	Yes	No
<u>** Correctol or Ex-Lax</u>	Yes	No	<u>** Stool Softener</u>	Yes	No
<u>Cough Drops</u>	Yes	No	<u>** Sudafed</u>	Yes	No
<u>** Cough Syrup</u>	Yes	No	<u>Triple Antibiotic Ointment</u>	Yes	No
<u>** Dramamine</u>	Yes	No	<u>Visine</u>	Yes	No

Date(s) medication is to be administered: From: August 20, 20 To: June 30, 20

PROVIDER'S NAME _____ **Date** _____

PROVIDER'S SIGNATURE _____ **Telephone No.** _____

I hereby request that school personnel administer the above medication, ordered by my licensed health care provider for my daughter. I must supply the school with any medication other than those indicated above. I understand that any over-the-counter medication supplied by me will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

PARENT'S or GUARDIAN'S NAME _____ **Date** _____

PARENT'S or GURADIAN'S SIGNATURE _____ **Telephone No.** _____

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