

**Wentzville School District
Non-Prescription Medication Authorization Form**

School: _____ Phone: (____) _____ - _____ Fax Number: (____) _____ - _____

Student: _____ Date of Birth: ____/____/____ Grade: _____

Tylenol/Acetaminophen

- Liquid 160mg/5ml _____ mls PO Q 4-6 hrs prn pain/fever
- Chewable 80mg _____ tabs PO Q 4-6 hrs prn pain/fever
- Tablets 325mg _____ tabs PO Q 4-6 hrs prn pain/fever
- Tablets 500mg _____ tabs PO Q 4-6 hrs prn pain/fever
- Other dosing: _____

Benadryl/Diphenhydramine

- Liquid 12.5mg/5ml _____ mls. PO Q 4-6 hrs prn allergy sx
- Chewable 12.5mg _____ tabs PO Q 4-6 hrs prn allergy sx
- Tabs/Caps 25mg _____ tabs/caps PO Q 4-6 hrs prn allergy sx
- Other dosing: _____

Zyrtec or **Claritin** (please check one)

- Liquid 12.5mg/5ml _____ mls. PO Q day prn allergy sx
- Chewable 5mg _____ tabs PO Q day prn allergy sx
- Tablets 10mg _____ tabs PO Q day prn allergy sx
- Other dosing: _____

Over the Age of 12 years

- Aleve/Naproxen** tabs/caps 220mg _____ tabs PO Q 8-12 hours prn pain
- Excedrin Extra Strength:** Acetaminophen 250mg/Aspirin 250mg/Caffeine 65 mg tabs _____ tabs PO Q 6-8 hours prn headache
- Midol Complete Tabs:** Acetaminophen 500mg/Caff 60mg/Pyrimilamine maleate 15mg tab _____ tabs PO Q 6 hours prn cramps/bloating/pain

Advil/Motrin/Ibuprofen

- Liquid 100mg/5ml _____ mls. PO Q 4-6 hrs prn pain/fever
- Chewable 50mg _____ tabs PO Q 6-8 hrs prn pain/fever
- Junior tabs 100mg _____ tabs PO Q 6-8 hrs prn pain/fever
- Tablets 200 mg _____ tabs PO Q 6-8 hrs prn pain/fever
- Other dosing: _____

Allergy (antihistamine) Eye Drops

- OTC Allergy eye drops: 1 drop OU Q 8-12 hrs prn eye allergy sx

Other (FDA approved only)

- Other Dosing: _____
- _____
- _____

PHYSICIAN AUTHORIZATION

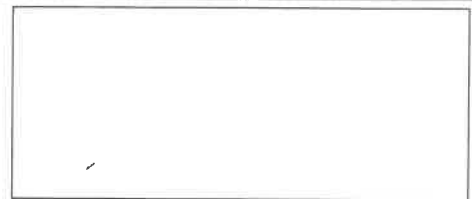
Prescriber's Name/Title: _____

Telephone: _____ Fax: _____

Prescriber's Signature: _____

(MD, NP, Or PA signature or signature stamp ONLY)

Date: ____/____/____



Use for Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I authorize the school nurse to communicate with the healthcare provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

This form is valid starting on the date signed by physician and will be in effect until the end of the current school year/summer session. Non-prescription medication must be in the original container with the label intact. An adult must bring the medication to school.