

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION FORM

**WINCHESTER PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL EDUCATION
12 N. WASHINGTON STREET
WINCHESTER, VA 22601**

**PARENTAL PERMISSION FOR DISPENSING OVER-THE-COUNTER
MEDICATIONS AT SCHOOL**

Child's Name: _____

Date: _____

You have my permission to give my child Acetaminophen extra strength capsules 500 mg (generic for Tylenol). Please note 1 or 2 if he/she is experiencing minor aches and pains, headache, toothache, dental pain or menstrual cramps with at least 4-hour interval between dosages.

Parent Signature Date

You have my permission to give my child Ibuprofen extra strength capsules 200 mg (generic for Motrin). Please note 1 or 2 if he/she is experiencing any strain, sprain, or menstrual cramps that could be relieved by administration of this anti-inflammatory/pain medication with at least a 4 to 6-hour interval between dosages.

Parent Signature Date

A **DOCTOR'S NOTE** will be required to dispense acetaminophen or ibuprofen (400 mg) for any other reason. No medication will be given to any child with a temperature of 100 degrees or above. Any illness, injury requiring further assessment will be reported to parents as soon as possible.

You have my permission to give my child Pepto-Bismol if he/she is complaining of an upset stomach.

Parent Signature Date

Comments/special considerations: _____

Approved:

June 2008
