HAWTHORNE VALLEY
waldorf school

Over the Counter Medication Authorization Form

Student Name _____ Date of Birth _____

* To be completed by Physician or Licensed Medical Personnel *

Please indicate approval for administration by circling YES or NO in the space indicated. This will serve as a standing physicians order for the 2019-2020 school year.

Medication	Route	Dosage	Schedule & Indications	Permission
Tylenol (acetaminophen)	By mouth (elixir or tablet)	Per label instructions by age and weight	Every 4 hours PRN pain or fever > ____F	YES / NO
Motrin or Advil (ibuprofen)	By mouth (elixir, suspension or tablets)	Per label instructions by age and weight	Every 4 hours PRN pain or fever > ____F	YES / NO
Benadryl (diphenhydramine HCl)	By mouth (elixir, tablets, or capsules)	Per label instructions by age and weight	Every 6 hours PRN allergies or insect bites	YES / NO
Claritin (loratidine)	By mouth (tablets)	10 mg	Daily PRN allergy symptoms	YES / NO
Tums (calcium carbonate)	By mouth (chewable tablets)	840mg	Every 2 hours PRN acid indigestion	YES / NO
Pepto Bismal (Bismuth Subsalicylate)	By mouth (syrup)	Per label instructions by age and weight	Every 2 hours PRN upset stomach	YES / NO
Calamine Lotion	Apply topically	Per label	PRN allergic reactions (contact dermatitis, insect bite)	YES / NO
Hydrocortisone Cream	Apply topically	Per label instructions	PRN allergic reactions (hives, insect bites)	YES / NO

_____
Physician/Healthcare Provider PRINT NAME

_____
Physician/Healthcare Provider SIGNATURE Date

_____(____)_____ -_____
Physician/Healthcare Provider Address Telephone

_____
Parent/Guardian PRINT NAME

_____
Parent/Guardian SIGNATURE Date