PITTSGROVE TOWNSHIP SCHOOLS
Pittsgrove, New Jersey 08318-3950

Permission to Administer OTC Medication

Student Name: _____ DOB: _____Grade: _____

Allergies:_____ Weight: _____pounds

Our School Physician, William Madison, DO, has authorized the administration of the following medication by the School Nurse in the School Health Office. Parent/guardian permission is required before a student can receive any of the listed medication. **No verbal permission will be accepted.** The School/Substitute Nurse, pursuant to N.J.A.C:.6A:16-2.3 may, with written parent permission, administer these medications as needed, based on nursing assessment, **no more than two times a month**. Dosage will be administered according to the student's weight per School Physician's standing orders. This medication permission form will be valid for the current school year. If your child should require a different dose to achieve analgesic relief, then you must obtain a physician's order. Only one dose is to be administered during the school day of either medication. If your child is going to require Acetaminophen/Ibuprofen on a regular basis, a medical note from your physician is required.

I give permission for the School Nurse to administer the age/weight-appropriate dose of the following medications to my son/daughter I understand that the school district, agents, and its employees shall incur no liability as a result of any condition or injury arising from the administration or lack of administration of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents, and employees against any claims arising out of administration or lack of administration of this medication.

I further understand that if my child has a headache due to an injury to his/her head, then Acetaminophen/ Ibuprofen cannot be given.

Acetaminophen/Ibuprofen will not be given for a temperature of 100 degrees or above.

Tylenol/Acetaminophen ❒ Yes ❒ No **Parent/Guardian Initials _____**

Advil/Ibuprofen ❒ Yes ❒ No **Parent/Guardian Initials _____**

Child's Weight	Acetaminophen Dose	Ibuprofen Dose
60 to 71 lbs.	325 mg	250 mg
72 to 95 lbs.	325 mg	300 mg
Over 95 lbs.	325 - 650 mg	200 - 400 mg

Parent/Guardian Signature: _____ Date: _____

Complaint	Date	Time	Medication/dose	Initials/*
September				
October				
November				
December				
January				
February				
March				
April				
May				
June				

* = parental contact

Nurse Signature	Initial	Nurse Signature	Initial