MUST BE SIGNED BY A DOCTOR EVERY YEAR!

Germantown Central School
Health Office 518-537-6281 Ext. 5
Fax 518-537-6115

Administration of PRN - Over the Counter Medications Permission Slip

Student Name: _____ DOB _____

Please **INITIAL** each individual medication you want to be available for your child throughout the 20____/20____ school year.

_____ Tylenol (acetaminophen) for headache, pain, discomfort or low-grade temp

_____ Advil (ibuprofen) for headache, pain, discomfort, or low-grade temp

_____ Tums (calcium carbonate) for upset stomach

_____ Throat lozenge for throat irritation, dryness, cough

_____ Benadryl for allergy symptoms

All medications will be administered according to manufacturer's recommendations unless otherwise noted.

_____

Physician's Name (please print) _____

PHYSICIAN'S SIGNATURE: _____

Phone number _____ Date_____

_____

I request that the Germantown Central School Nurses to administer the above initialed medications to my child as prescribed by our Physician.

Parent Name (please print) _____

Parent's Signature _____ Date _____

Phone number _____

ALL MEDICATIONS MUST BE BROUGHT TO SCHOOL BY AN ADULT IN THE ORIGINAL CONTAINER.