Last Name: First Name: DOB:

Gardner Public Schools

Parent Authorization for Over-the-Counter Medications

Please check the appropriate medication(s) listed below if you wish to have your child receive them during school hours. I hereby authorize the school nurse to administer:

______**Acetaminophen (Tylenol) < or = 500mg, (dose to be determined by weight) every 4 hours as needed for headache, fever or pain.**
Possible side effects: well tolerated, rare hypersensitivity reaction. Adverse reactions: loss of Appetite, nausea, diaphoresis, generalized weakness within 1st 12-24 hrs. Later signs of toxicity: vomiting, Right upper quadrant pain, elevated liver function tests. Contraindications: hypersensitivity.

_______**Ibuprofen (Advil, Motrin) < or = 400 mg, (dose to be determined by weight) every 6 hours as needed for headache, fever, or pain when nausea is not present. Do not give on empty stomach.**
Adverse Reactions: dizziness, headache, nervousness, edema, fluid retention, tinnitus, abdominal pain, bloating, constipation, decreased appetite, diarrhea, dyspepsia, epgastric distress, flatulence, heartburn, nausea, nonnectrotizing enterocolitis, vomiting.

_______**Antacid (Tums) 1-2 tablets every 4 hours as needed for upset stomach, heart burn.**
Possible side effects: constipation, nausea, GI upset, loss of appetite. Contraindications: allergy to calcium, Renal calculi, hypercalcemia.

All students must have a signed and completed parental authorization form on file with the nurse before ANY medication will be administered. These forms are for the current school year only. Medications will be administered according to the medication policy approved by the Gardner School Committee. Any changes to the above information over the course of the school year must be reported to the school nurse.

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Kathleen Sweeney, MD.-School Physician

The following information is **REQUIRED** before any medication will be administered

Allergies:

Medications: ____

Food: ____

Please list **ALL** medications (prescription and over-the-counter) that the student is taking:

____

I give permission for my child, Name:_________________________, DOB:_______________, Grade:______________
to be given the medication I have checked off above, by the school nurse.

__________________________________ ____________________
Signature of Parent/Guardian Date

Updated: July 2019