First Lutheran School
ENGAGE. INSPIRE. ACHIEVE.

2900 Carson St. Torrance, CA 90503
310-320-9920 FAX 310-320-1963

Authorization for Administration of Over The Counter Medication

TK through 3rd Grade

2021-2022

Name of Child:_____ Date of Birth_____ Grade_____ Weight_____

MEDICATION	TYPE	DOSE	REASON
Circle desired medication	*Circle preferred type medication*	*Enter # of tsp, # of tabs, or "as directed:*	
Ibuprofen	*Liquid* 100 mg/tsp *Jr. Strength Chewable* 100 mg tab		Pain, fever
Acetaminophen	*Liquid* 160mg/tsp *Chew Tab* 160mg *Regular Tab* 325mg (6yrs+)		Pain, fever
Cough Drop			Cough, Sore throat
Benadryl	*Liquid* 12.5 mg/tsp *Chewable/MeltAwayTab* 12.5mg (6yrs+) *Capsule* 25mg (6yrs+)		Allergies
Sudafed **Sudafed 12 hour**	*Liquid* 15mg/tsp *Tablet* 30mg (6yrs+)		Nasal congestion, cold symptoms
Dramamine	*Chewable Tab* 50mg *Tablet* 50mg		Motion Sickness
Other OTC med supplied by family			Please state:

Parent and Physician Signatures REQUIRED on 2nd Page

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MEDICATION	TYPE	DOSE	REASON
Circle the desired medication		*State frequency or "as directed"*	
Kids' Tums (2-12 years)	*Chewable* 750mg		Upset stomach
Children's Pepto-Bismol (2-11 years old)	*Chewable* 400mg tab		Nausea, vomiting
Triple Antibiotic Ointment	*Topical*		Cuts and abrasions
Benadryl Cream	*Topical*		Rash or insect bite
Hydrocortisone Ointment 1%	*Topical*		Rash
Pain Relief	*Topical*		Muscle soreness
Sting Relief	*Topical*		Insect bite or sting

TO BE COMPLETED BY THE PHYSICIAN

Signature of MD:_____ M.D. Name (Print)_____

Date:_____ M.D. Phone _____

TO BE COMPLETED BY THE PARENT

Student's Name_____ Grade_____

PARENTS RESPONSIBILITY: As a parent of the above named child, I give my full consent for the personnel of the school to administer the medication as described above. It is hereby understood that the school is providing this service as a benefit to the parents and, therefore, assumes absolutely no responsibility with respect to the medical treatment for the child's condition. The parents hereby agree to release the school from any and all claims that may result from the administration of medication as requested by the parent and physician.

Parent Signature_____Date_____

Day Phone_____ Cell Phone_____