THE FORUM SCHOOL
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Waldwick, NJ 07443

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AUTHORIZATION TO ADMINISTER OVER-THE-COUNTER MEDICATION IN SCHOOL

Dear Parent/Legal Guardian:

To request any medication administration at school, please note:

- This form must be completed and **signed by you and your child's medical provider**.
- This medication order is **valid for the entire school year**, including summer program unless otherwise specified.
- **ALL over-the counter medications**, including pain relievers, vitamins and homeopathic treatments **require a physician order and parents/guardians signature.**

Name of Student: _____

I authorize the school nurse to administer the following over-the-counter medication:

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	REASON PRESCRIBED	SIDE EFFECTS
Acetaminophen (Tylenol)				
Ibuprofen (Advil, Motrin)				
Cough drops				

Physician's Signature _____ Date:_____

Address: _____ Phone:_____

PARENT/GUARDIAN AUTHORIZATION

I request that my child _____ receive the medication as prescribed by our physician as needed.

Parent/Guardian Signature: _____