

North Hunterdon High School

Revised 11/07

Health Office

1445 Route 31 South

Annandale NJ 08801

Phone: 713-4171 Fax: 713-4403

Over - the - Counter Medication Administration
Yearly Parent/ Guardian Permission

Student's Name _____ **Grade** _____

Medication Allergies YES NO If yes, please list _____

Medical Conditions: _____

I give the School Nurse permission to administer the following medications to my child when needed at school. Please write YES or NO in each space. If your child is **allergic** to any of the medications, please write "allergic" in the space below.

_____ **Acetaminophen** (Tylenol) 650mg.

_____ **Ibuprofen** (Advil, Motrin) 400mg

_____ **Maalox-** 1 to 2 chewable tablets or
2 to 4 teaspoons of liquid

***If medication is used in excess, a request will be sent home to have the student evaluated by your family physician.

I will advise the school nurse if, for any reason, my child should not be taking any of these medications in the future.

Parent/ Guardian Signature

Date

Phone Number