

# **OVER THE COUNTER MEDICATION APPROVAL FORM**

**Tapestry Charter School, Grades K-5  
Health Office**

**Must be completed by the parent and doctor.**

I request the school nurse give the medication listed on this plan.

<i>If any medication listed is needed for 5 days straight, a referral will be sent home and a call will be placed to the parents with a recommendation for the student to be seen by a doctor.</i>	Parent (initial)	Medical Provider (initial)
*Tylenol liquid _____ q4hrs for pain, headache or temp>100		
*Motrin liquid _____ q6hrs for pain, headache or temp >100		
Cough Drops 1 tab q2 hrs./prn for cough or throat irritation		
Hydrocortisone cream 1% topically for itching or irritation		
Sterile water eye wash for eye irritation		
Other:		

***\*Physician please complete order with desired amount to be given.***

This plan is valid for the 2019-2020 school year.

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

Prescriber's name and title \_\_\_\_\_

Prescriber's signature \_\_\_\_\_ Date \_\_\_\_\_