OVER THE COUNTER
MEDICATION APPROVAL FORM

Tapestry Charter School, Grades K-4
Health Office

Must be completed by the parent and doctor.

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

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.	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____________