OVER THE COUNTER
MEDICATION APPROVAL FORM 2024-25

Tapestry Charter School Health Office
Grades K-4

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

STUDENT NAME: _____ Gr. _____

I request the school nurse give the medication listed on this plan, to the above mentioned student, if needed during the school year.

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 the order with the desired amount to be given.
This plan is valid for the 2024-2025 school year.

Parent signature_____Date_____

Prescriber's name and title_____

Prescriber's signature_____ Date_____