Immaculate Heart of Mary School Over the Counter Medication Form  
School Year 2023-2024

Student Name: __________________________________ Grade: ________

The following form may be used to administer the listed Over-The-Counter Medications to your child during the school day.

○ ACETAMINOPHEN: ORALLY every 4 hours, AS NEEDED, according to weight for headache, fevers, dysmenorrhea or mild to moderate discomfort. Dosage: __________________________________________________________

○ IBUPROFEN: ORALLY every 6-8 hours, AS NEEDED, according to weight, for mild to moderate discomfort, headache, fever, dysmenorrhea. Dosage: ______________________________________________________________

○ DIPHENHYDRAMINE: (Benadryl) ORALLY, Every 4-6 Hours, AS NEEDED, according to weight, for mild allergic reactions or per anaphylaxis protocol. Dosage: ___________________________________________________________

○ Allergy Medication: Name and Dosage: _____________________________ ____________________________________________________________.

○ ANTACID TABLETS: 1 to 3 tablets, ORALLY, for up to 2 doses, AS NEEDED, for mild to moderate gastric hyperacidity.

○ COUGH DROPS: Are at the parent’s discretion and will not be supplied at school.

This form MUST BE SIGNED BY YOU and YOUR CHILD’S PHYSICIAN.

____________________________________________________________________
Parent/ Guardian Signature Date

____________________________________________________________________
Physician’s Signature Date

(This order is effective from August 21, 2023 - June 28, 2024.)