# 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.

**<u>This form MUST BE SIGNED BY YOU and YOUR CHILD'S PHYSICIAN.</u>**

_____
Parent/ Guardian Signature Date

_____
Physician's Signature Date

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