LABBB Health Office at Lexington High School
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Tel: 781-861-2400 ext 1009
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OVER THE COUNTER (OTC) MEDICATION ORDER FORM
FOR ELEMENTARY AND MIDDLE SCHOOL STUDENTS
**** PLEASE NOTE: A DOCTOR'S SIGNATURE IS REQUIRED FOR OTC MEDICATIONS ****

Student name: _____ DOB: _____ Allergies: _____

Acetaminophen (Tylenol):

Dose: _____ Route: _____ Frequency: _____ Reasons: _____

Ibuprofen (Advil):

Dose: _____ Route: _____ Frequency: _____ Reasons: _____

Tums:

Dose: _____ Route: _____ Frequency: _____ Reasons: _____

Other Over the Counter Medications (must be provided by parent/guardian):

Medication: _____

Dose: _____ Route: _____ Frequency: _____ Reasons: _____

Medication: _____

Dose: _____ Route: _____ Frequency: _____ Reasons: _____

Prescriber signature: _____ **Date:** _____

Prescriber name: _____ **Phone:** _____

Parent/Guardian Authorization for Medication Administration:
I, the undersigned, give permission to the school nurse to administer the above medication.

Parent/Guardian signature: _____ Date: _____

Parent/Guardian telephone (home and work): _____

LABBB Nurse signature: _____ Date: _____