



**LABBB Health Office at Lexington High School**

251 Waltham St. Lexington, MA 02421

Tel: 781-861-2400 ext 1009

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**OVER THE COUNTER (OTC) MEDICATION ORDER FORM**

**\*\*PLEASE NOTE: A DOCTOR'S SIGNATURE IS REQUIRED FOR OTC MEDICATIONS\*\***

Student: \_\_\_\_\_ 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: \_\_\_\_\_

Prescriber phone: \_\_\_\_\_

**Parent/Guardian Authorization for Medication Administration**

I the undersigned give permission to the school nurse and delegated personnel to administer the above medication.

Parent /Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Telephone (Home and Work) \_\_\_\_\_

LABBB Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature (if over 18): \_\_\_\_\_ Date: \_\_\_\_\_