

2010-2011
St. Anthony School
119 W. Springfield, Sullivan, Mo. 63080
573-468-4423 School Phone
573- 468-3428 Fax

**PHYSICIAN AUTHORIZATION FOR
OVER THE COUNTER MEDICATIONS**

Name of Student _____ Date of birth _____

Address _____ Grade _____
Street City/State/ZIP

Name of Licensed Prescriber _____ Title _____

Doctor's Telephone Number _____

I HAVE DETERMINED THAT IT IS NECESSARY FOR THIS MEDICATION TO BE
ADMINISTERED DURING SCHOOL HOURS AS PER PARENT/GUARDIAN
INSTRUCTIONS.

Please circle the medications that may be given at school. Medication will be given as
per product instructions:

Acetaminophen	Aloe	Antacids
Antibiotic ointment	Benadryl cream	Benadryl oral
Burn gel	Calamine lotion	Cornstarch
Cough drops	Desitin	Hand lotion
Heating pad	Hydrocortisone cream	Hydrogen peroxide
Ibuprofen	Oragel	Petroleum jelly
Rubbing alcohol	Saline solution	Splinter removal
Sunscreen	Zinc oxide	
Other: _____		

Other specific directions or information regarding this medication/administration:

Specific side effects, contraindications or possible adverse reactions to be observed:

Signature of licensed prescriber

Signature of parent/guardian

Title

Date

Date