BERMAN
MELVIN J. BERMAN HEBREW ACADEMY

PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATION

As required by the state of Maryland, Berman Hebrew Academy will administer over the counter medication to a student with **written consent of both the parents and the physician. No over the counter medication will be administered unless this form is on file.**

____I authorize the school nurse to use her discretion to give my child any of the initialed medications noted below.

____I wish to be called before the school nurse administers the following medications:
_____.

____I wish to be called before the school nurse dispenses any medication.
____I do not want my child to receive any medication at school.

Student name _____ Grade _____

Parent signature _____ Date _____

Over the counter medications: ***Please indicate dosage where applicable.***

Acetaminophen	____	Hydrocortisone cream	____
Antibiotic ointment	____	***Ibuprofen***	____
__Benadryl (generic)__	____	Saline eye irrigation	____
Calagel lotion	____	Cough drops	____
Contact lens solution	____	Tums	____

My child has medication allergies (please check)
____ Yes ____ No If yes, please list here: _____

_____

*If child has a known allergy that may require Benadryl, the *Medication Administration Authorization form* must be completed

FOR PHYSICIAN

This student can receive the medications initialed above.

_____
Physician signature Date

_____
Physician name or stamp