

**HOLY FAMILY SCHOOL
OVER THE COUNTER MEDICATION
AUTHORIZATION FORM**

To be completed and signed by a licensed Physician and parent/guardian

Student's Name _____ Grade _____

1. Headache/ Fever > 100/ Menstrual Pain / Braces Teeth Pain / Sports Injury

_____ (check) **Children's Acetaminophen (160mg/tsp)**
orally every 6 hours as needed
weight _____ dose
24-35lbs 160mg (1tsp)
36-47lbs 240mg (1 1/2 tsp)
48-59lbs 320mg (2 tsp)
60-71lbs 400mg (2 1/2tsp)
72-95lbs 480mg (3tsp)

_____ (check) **Regular Acetaminophen (325mg/tab)**
orally every 6 hours as needed
weight _____ dose
>95lbs 325mg (1-2tabs)

_____ (check) **Children's Ibuprofen (100mg/tsp)**
orally every 6 hours as needed
weight _____ dose
24-35lbs 100mg (1tsp)
36-47lbs 150mg (1 1/2 tsp)
48-59lbs 200mg (2 tsp)
60-71lbs 250mg (2 1/2tsp)
72-95lbs 300mg (3tsp)

_____ (check) **Regular Ibuprofen (200mg/tab)**
orally every 6 hours as needed
weight _____ dose
>95lbs 200mg (1 tab)

2. Seasonal Allergy/ Sneezing / Runny Nose

_____ (check) **Children's Diphenhydramine 12.5 - 25 mg**
Orally every 6 hours as needed (ages 6-13 yrs)

Signature of Physician

Print name of Physician

Signature of Parent/Guardian

Date