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
24-35 lbs	160mg (1 tsp)
36-47 lbs	240mg (1 1/2 tsp)
48-59 lbs	320mg (2 tsp)
60-71 lbs	400mg (2 1/2 tsp)
72-95 lbs	480mg (3 tsp)

____(check) **Regular Acetaminophen (325mg/tsp)**
orally every 6 hours as needed

weight	dose
> 95 lbs	325mg (1-2 tabs)

____(check) **Children's Ibuprofen (100mg/tsp)**
orally every 6 hours as needed

weight	dose
24-35 lbs	100mg (1 tsp)
36-47 lbs	150mg (1 1/2 tsp)
48-59 lbs	200mg (2 tsp)
60-71 lbs	250mg (2 1/2 tsp)
72-95 lbs	300mg (3 tsp)

____(check) **Regular Ibuprofen (200mg/tsp)**
orally every 6 hours as needed

weight	dose
> 95 lbs	200mg (1-2 tabs)

2. Seasonal Allergy / Sneezing / Runny Nose

____(check) **Children's Diphenhydramine 12.5 - 25mg**
orally every 6 hours as needed (ages 6-13 years)

_____ _____
Signature of Physician Print name of Physician

_____ _____
Signature of Parent/Guardian Date