Winthrop High School

151 Pauline Street, Winthrop, Ma 02152
Phone (617) 846-5505 – Fax (617) 539-0535
Mr. Matthew Crombie, Principal – Mr. Michael Capasso Vice-Principal

Over The Counter Medication Permission Form

Name: ________________________________ YOG: ________

Allergies: ________________________________

I give permission to the school nurse to administer the following medications to my child according to established protocols. I have crossed out any products I do not want my child to receive.

All other medications, including inhalers, require a written order from a licensed prescriber (physician, dentist, nurse practitioner) and written parental permission. Medication is to be sent to school in the original container. Your pharmacy can give you a duplicate container for school.

Acetaminophen 325mg:	1-2 tablets every four hours as needed for pain, injury, or fever.
Ibuprofen 200mg:	1-2 tablets every 6 hours as needed for injury or pain.
Antibiotic Ointment:	As needed for cuts, scrapes, etc. 1-3 times daily
Caladryl:	As needed to relieve itching from poison ivy, sumac, oak, or insect bites.
Oral Pain Gel	As needed to affected area for tooth pain or mouth irritations four times per day.
Antacids:	2 tablets for upset stomach, heartburn, or sour stomach. Not to exceed 6 daily

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Parent/Guardian Signature Date