

Foxborough Regional Charter School
131 Central Street
Foxborough, MA 02035

Phone: (508) 543-2508

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Health Services

**Over the counter Medications
Grades 6-12**

Student _____ Grade _____ Date of birth _____

Name of Parent/ Guardian _____

Home Phone _____ Work _____ Emergency _____

My son/daughter has the following allergies: _____

Please list any medications your child is currently taking: _____

In consideration thereof, I hereby hold the school or any officer, agent, or servant thereof, harmless of any liability arising out of the administration of said medication to my child.

Consent:

I give permission to have the school nurse administer the following:

Tylenol- Acetaminophen: (325 mg)

Benadryl: (25mg)

Ibuprofen: (200mg)

Complaint: Headache, brace pain, menstrual cramps, sore throat, rash mild allergic reaction, injury, indicate other concern; _____(Circle one)

Administration: every 4-6 hours as needed

Dosage: according to the recommended dosage on the medication label to my child:

Name: _____

Licensed Prescriber (School Physician) Dr. Giuliano MD

I will provide the school nurse with a bottle of Tylenol/ Acetaminophen, Benadryl, or Ibuprofen as need with its original label and seal intact, or cough drops.

Parent/ Guardian signature: _____

***This form must be renewed in writing every year. This protocol covers only the medications listed.**