



**The Abraham Joshua Heschel School**  
**Miriam & Isaac Blech Early Childhood Center**  
**Henry Lindenbaum Lower School**  
 270 West 89<sup>th</sup> Street, New York, NY 10024  
**The Joseph Slifka Middle School**  
 314 West 91<sup>st</sup> Street, New York, NY 10024  
**The Abraham Joshua Heschel High School**  
**The Joseph and Sylvia Slifka Building**  
 20 West End Avenue, New York, NY, 10023

**MUST BE SIGNED BY  
 PHYSICIAN  
 ONE FORM PER CHILD**

**PARENT AND PRESCRIBERS' AUTHORIZATION FOR ADMINISTRATION OF  
 OTC (Over the Counter) MEDICATION IN SCHOOL 2010-2011**  
*Authorization for Administration of Medication*

**A. To be completed by a licensed health care professional:**

I request that my patient, named below, receive the following OTC medications in the event of headache, low grade fever, allergic reaction, sore throat, minor cuts, or stomach ailments on an 'as needed' basis. **(CHECK ANY for which permission is GIVEN):**

- |  |  |
|--|--|
| <input type="checkbox"/> Acetaminophen (Tylenol)               | <input type="checkbox"/> Ibuprofen (Motrin, Advil) |
| Dosage/Frequency: _____  | Dosage/Frequency: _____                            |
| <input type="checkbox"/> Benadryl                              | <input type="checkbox"/> Antacid (Maalox, Tums)    |
| Dosage/Frequency: _____  | Dosage/Frequency: _____                            |
| <input type="checkbox"/> Cough Drop                            | <input type="checkbox"/> Antibiotic Ointment       |
| <input type="checkbox"/> Other: _____                          | <input type="checkbox"/> Hydrocortisone Cream      |
| <input type="checkbox"/> <b>Prescription Medication:</b> _____ |  |

**Special instructions and/or restrictions:**

\_\_\_\_\_  
 \_\_\_\_\_

Name of Licensed Prescriber and Title (Please print): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Stamp/Print:

Name:

Address:

Phone:

**B. To be completed by Parent or Guardian:**

I request that my child \_\_\_\_\_ in grade/class \_\_\_\_\_ receive the OTC medication(s) as directed above by our licensed health care prescriber. I give the Heschel School permission to administer the medication(s) in the event of headache, low-grade fever, allergic reaction, sore throat, minor cuts, or stomach ailments on an as needed basis. I understand that the school nurse will administer the medication or an adult with First Aid training will supervise my child taking his/her own medication.

Signature (Parent or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_