Foxborough Regional Charter School
131 Central Street
Foxborough, MA 02035

Phone: (508) 543-2508 Fax (508) 543-5314

Health Services

Over the counter Medications
Grades 5-12

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 - 650mg)

Benadryl: (25mg)

Ibuprofen: (200 - 400 mg)

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.**