North Warren Regional School District
Health Office
10 Noe Road
Blairstown, NJ 07825

Permission for Administration of School Physician Ordered Medications
FORM C

Student Name:_____ Grade:_____

The School Physician's orders allow for administration of the following medications with parental permission. Please sign and date each medication that you will allow your child to have administered by the school nurse during school hours.

Tylenol 650 mg every four hours as needed for headache/pain

Parent/Guardian Signature:_____ Date:_____

Ibuprofen 200mg for weight above 100 lbs

Parent/Guardian Signature:_____ Date:_____

Ibuprofen 100mg for weight under 100 lbs.

Parent/Guardian Signature:_____ Date:_____

Throat Lozenges/ Cough Drops as needed for cough or sore throat unaccompanied by fever

Parent/Guardian Signature:_____ Date:_____

Benadryl 25mg (one dose), in the event of allergic reaction

Parent/Guardian Signature:_____ Date:_____