LABBB Health Office at Lexington High School
251 Waltham St. Lexington, MA 02421
Tel: 781-861-2400 ext 1009
Fax: 781-861-1351
Email: healthoffice@labbb.net

Parent/Guardian Authorization for Over-the-Counter Medication Administration for LABBB High School Students

Student name: _____ **DOB:** _____

Parent/Guardian name: _____

Home telephone number: _____

Work telephone number: _____

Mobile telephone number: _____

Please give my student the following **oral** medication(s) in school as indicated per school protocol:

- □ **Acetaminophen (tablet or liquid)**
- □ **Ibuprofen (tablet or liquid)**
- □ **Tums (chewable)**
- □ **Cough drops (Menthol)**

Please give my student the following **topical** medication(s) in school as indicated per school protocol:

- □ **Bacitracin (antibiotic ointment)**

My student has the following allergies: _____

My student is currently taking the following medications (to be completed if not in violation of confidentiality):

_____

_____

Parent/Guardian Authorization for Medication Administration:
I, the undersigned, give permission to the school nurse to administer the above medication(s).

Parent/Guardian signature: _____ Date: _____

Student signature (if over 18): _____ Date: _____