



ELEMENTARY SCHOOL

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HIGH SCHOOL | LIFE ACADEMY

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Authorization for Non-Prescription Medication

I _____, give permission to the School Nurse to give the following non-prescription medications to my child during school hours. These medications are in stock in the Nurse’s Office.

Please **CHECK** the medications and dosage amounts you are allowing to be administered.

1. Acetaminophen (Tylenol)- For headache, pain, or fever
 - Children’s Chewable
 - Children’s Liquid
 - Regular Strength Tablets
2. Ibuprofen (Motrin)- For headache, pain, or fever
 - Regular Strength Tablets
3. Tums- For upset stomach
 - 1 tablet
 - 2 tablets
4. Eye drops- For red/itchy eyes due to seasonal allergies
 - Yes
 - No
5. Benadryl/Diphenhydramine- Allergic Reaction
 - Yes
 - No
6. Nebulizer/Albuterol -For an unknown asthmatic in respiratory distress
 - Yes
 - No

****Any medications, other than those listed above, will need a physician’s order and must be provided by you in an original labeled container.**

Student’s Name: _____ Date: _____

Parent/Guardian Signature: _____