Parent Authorization for Over the Counter (OTC) Medication Administration

Student Name_____ Date of Birth_____

Parent/Guardian Name_____

Telephone Number_____ Work Number_____

I am requesting the School Nurse or designated school personnel to administer the following OTC (over the counter) medication such as:

Acetaminophen-Tylenol

PLEASE CIRCLE ONE OR BOTH

Ibuprofen

I give my permission:

Yes No **Circle one**

If your child requests these meds on regular bases <u>you may</u> be asked to supply his or her own pain reliever. These are the only meds the school carries. **No cough drops and sore throat meds.**

Any other medicine given at school must have a prescribed medicine form filled out before the school can dispense the meds. You can pick these up at the office and fill them out when you bring the medicine in. If you have any questions please feel free to give me a call. Julie Fields 680-3333

Parent/Guardian Signature:_____