Dispensing of Over the Counter Medication to Students

ONLY FILL OUT TOP OR BOTTOM NOT BOTH!

Medication Be Renewed at the Start of Each School Year

Student Name_____ Grade_____

I,_____ Being the Parent/Guardian of the above named student give the school nurse or office staff permission to administer over the counter medication such as Tylenol, Ibuprofen, Pepto-Bismol, Benadryl, cough drops or cough medicine as needed by the above named student during school hours.

Parent/Guardian Signature_____ Date_____
(Sign this line only if you agree with the above statement)

I, _____Being the Parent/Guardian of the above named student would prefer to be called in the event my child needs to have any over the counter medication administered during school hours.

Parent/Guardian Signature_____ Date_____
(Sign this line only if you agree with the above statement)

Emergency Contact who I authorize to give permission in the event I cannot be reached:

Name_____ Phone_____