

**PARENTAL PERMISSION FOR OVER THE COUNTER (OTC) MEDICATION
TO BE ADMINISTERED BY THE NURSE**

PARENTAL PERMISSION I request that my child _____ Grade _____

be administered the following OTC medications by the school nurse if needed during the school day:

- MEDICATION**
- Tylenol (acetaminophen) for pain or fever
 - Motrin or Advil (ibuprofen) for pain or fever
 - Cough & Cold Medicine (including cough drops) (specify) _____
(Parents must supply)
 - Benadryl for rash or allergy
 - Tums
 - Other (specify) _____

DOSE Per label

FREQUENCY As needed

I do NOT wish for my child to receive any OTC medications.

Parent/Guardian Signature _____ Date _____

Permission for medication is effective only for the current school year and needs to be renewed for each subsequent school year. I assume full responsibility for the administration of the above medication/s and will inform the school nurse of any change in medication or health status. **Please note: if your child takes OTC medications, please send medication with child's name on it.**

*******PHYSICIAN'S PERMISSION*******

I hereby authorize the school nurse to administer the OTC medication/s as approved above.

Physician's Signature _____ Stamp _____

Date _____ Address/Phone _____

Please return this form to the Front Office by August 1. Thank you.