OVER –THE-COUNTER MEDICATION PERMISSION FORM

Student Name Birthdate Grade School Year

OVER-THE COUNTER MEDICATION

By initialing below, I give permission for school personnel to administer the following medication(s) as needed to my student for minor discomfort or injury. This will not require an IHP (individual health plan). However, if student requires other medications an IHP will be necessary. Medications supplied by school may vary between building and grade levels.

_____Acetaminophen (Tylenol) Tablets or Liquid

_____Neosporin

_____Glucose Tablets

_____Glucose Gel

_____Tums

_____Benadryl Tabs or Liquid

_____Cough Drops

_____Hydrocortisone Cream

Parents may also supply other over the counter medications. Example Motrin Please list below:

Medication name: _____ Dosage: _____

Reason Given: _____ Time: _____

Medication name: _____ Dosage: _____

Reason Given: _____ Time: _____

Medication name: _____ Dosage: _____

Reason Given: _____ Time: _____

School Personnel who administer over-the-counter medication according to proper dosing instructions shall be held harmless for any adverse reaction experienced by the student. My student has previously take the medication(s) listed above with no known adverse reaction.

Parent/Guardian printed name:

Parent/guardian Signature: