PERMISSION FOR (OTC) OVER-THE-COUNTER MEDICATION

TO BE ADMINISTERED BY THE SCHOOL NURSE

2016 - 2017

PLEASE NOTE: *Permission must be updated each school year*!

My child _____ Grade _____

has my permission to receive the following OTC medication by the school nurse:

Medication: (Please ✓)

Tylenol	(acetaminophen)	325 mg.	2 tabs	_____
Advil	(ibuprofen)	200 mg.	1 tab	_____
			2 tabs	_____
Benadryl		25 mg.	1 cap	_____

Other: _____

Frequency: _____

Reason for Use: _____

_____ Date _____

Signature of Parent/Guardian ***(required)***

PHYSICIAN'S PERMISSION

I hereby authorize the school nurse to administer the above OTC medication.

_____ _____

Please stamp M.D. Name ***(required)*** M.D. Signature ***(required)***

_____ Date _____

Address/Phone Number

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE.