Grade _______________

SCARBOROUGH SCHOOL DEPARTMENT
HEALTH SERVICES
P.O. BOX 370
SCARBOROUGH, ME 04070-0370
PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS IN SCHOOL

SCHOOL: ______________________

STUDENT's NAME: ____

NAME OF MEDICATION:
Tylenol (acetaminophen) ____________________________
Advil (ibuprofen) __________________________________

DOSEAGE AND AMOUNT: _____________________________________

TIME TO BE GIVEN: ____
As needed
Today only

REASON FOR MEDICATION:
Pain____
Fever____
Other ____

I request and give permission for school personnel to administer the above medication to the above named student.

Signature of Parent/Guardian: _____________________________________

Date: _________________

This permission form is valid for ___________ school year only.

Comments: