Over-the-Counter Medication Permission Form

Student's Name: ______________________________ Date of Birth: ______________________________

Allergies: ____

I give permission to the school nurse/licensed provider to administer for the 2017-2018 academic year:

Medication	Dose	Frequency	Physician Signature
Tylenol			
Advil			
Benadryl			
TUMS			

Physician's Signature: ______________________________ Date: ______________

Parent Signature: ______________________________ Date: ______________