

**Hyde Park Elementary School**  
**50 E. Main Street**  
**Hyde Park, VT 05655**  
Health Office  
Phone: 802-521-5409  
Fax: 802-888-8591

**OVER-THE-COUNTER MEDICATION PERMISSION**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

**Medication Information:**

Name of Medication: \_\_\_\_\_ Strength: \_\_\_\_\_

Directions: \_\_\_\_\_

\*Please note, all over-the-counter medications must be administered according to the manufacturer's directions. Any dose outside of packaging guidelines must have a physician's order.\*

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Reason: \_\_\_\_\_

**Parental Permission:**

I give permission for the HPES school nurse, or her designee, to administer the above medication to my child during school.

I have read and understand the HPES medication policy, found in the student handbook and on the HPES Health Office website. I agree to adhere to these guidelines.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_ Date Received: \_\_\_\_\_