



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 2021–2022 academic year:

Medication	Dose	Frequency	Physician Signature
Tylenol			
Advil			
Benadryl			
TUMS			

Physician's Signature: _____ Date: _____

Parent Signature: _____ Date: _____