



North Polk Community School District  
Student Over-the-Counter Medication Permission Form



Student Name: \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

I grant permission to give my child the appropriate dose of the following medications when needed.

If your child is requesting Ibuprofen or Tylenol more than 2 days in a row or we have dispensed it 5 times in a semester we will contact you and may request parent to supply medication for child.

\_\_\_\_\_ Ibuprofen      \_\_\_\_\_ Acetaminophen      \_\_\_\_\_ Tums      \_\_\_\_\_ Benadryl

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

*For Nursing Office use only:*

Date/Time	Medication/Dosage	Reason	Initials
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____
16.	_____	_____	_____
17.	_____	_____	_____
18.	_____	_____	_____
19.	_____	_____	_____
20.	_____	_____	_____

Initial Name \_\_\_\_\_ Title \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_