Scarborough Public Schools Health Services
P.O. Box 370
Scarborough, ME 04070-0370
Phone: (207) 730-4100
Fax: (207) 730-4104

PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS IN SCHOOL

School:	Grade:
Student Name:	Date of Birth:
Allergies:	
Other Medical Information:	

I give permission for the Health Services Department to administer by mouth

to_____in age/weight appropriate dose:
(Students Name)

Acetaminophen (Tylenol): Yes ☐ No ☐

Ibuprofen (Advil/Motrin): Yes ☐ No ☐

*Calcium Carbonate (Tums): Yes ☐ No ☐
Middle School and High School Only

I understand and agree that the above information may be shared with the appropriate school personnel

Parent/Guardian Signature: _____Date: _____

This permission form is valid for the current school year only, must be resigned each year