

Permission to administer NON-PRESCRIPTION medications during school attendance

COMPLETED by PARENT / GUARDIAN:

Student: _____ Grade: _____

I give my permission for school personnel to administer over the counter medication (s) to the above name student for minor discomforts and injuries.

Please check YES or NO for all of the following:

- | | | | | | |
|------------------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|---------------------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Antibiotic ointment | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Ibuprofen (generic for Advil, Motrin) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hydrocortisone cream | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Acetaminophen (generic for Tylenol) |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Antiseptic cleanser | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Cough drops |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Antacid (generic for Tums) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Eye drops (non-medicated) |

COMPLETED by PARENT / GUARDIAN:

Permission to administer NON-prescription medications during school attendance, other than those listed above:

If a student brings any medication from home it must be in the ORIGINAL container, labeled with the student's name and accompanied by this permission form signed by the parent/guardian

Medication: _____ Dosage: _____ Date of Initial Dosage: _____

Reason for Medication: _____

Instructions for Administration: _____

Time of day Rx to be given: After Lunch As Needed Other Time: _____

Anticipated duration of Rx at school: School Year Other: _____

PRINTED name of Parent / Guardian: _____

I understand that any school employee who administers any of the above medications, in accordance with the prescription and/or over the counter directions, to my student shall not be liable for damages as a result of an adverse reaction suffered by the student due to this administration. I further acknowledge that the above student has taken the medication(s) previously (or the initial dosage) and has experienced no adverse reactions

Parent/Guardian Signature (Required)

Date