CONSENT FOR ADMINISTRATION OF OVER THE COUNTER MEDICATIONS
WINCHESTER PREK

Student's Name:_____ **Grade**:_____ **School Year** _____

Known Allergies:_____

List any long-term medications student is now receiving:_____

Check the over-the-counter medications listed below that will be available to your child at school. Please indicate dosage if applicable.

Check if Yes	**Medication**	**Dosage/Route (liquid or chewable)**
_____	Advil (Ibuprofen)	_____
_____	Tylenol (Acetaminophen)	_____
_____	Anti-itch cream (Hydrocortisone)	
_____	Antibiotic Ointment (Triple antibiotic)	
_____	I do ***NOT*** want any medication given to my child in school.	

Parent/Guardian Signature | Home Phone | Work Phone | Date

Physician's Signature | Office Phone | Office Fax | Date