CONSENT FOR ADMINISTRATION OF OVER THE COUNTER MEDICATIONS

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, chewable or swallowable)**
_____	Advil (Ibuprofen)	_____
_____	Tylenol (Acetaminophen)	_____
_____	Benadryl (Diphenhydramine)	_____
_____	Antacid Tablets (Tums)	_____

_____ Anti-itch cream (Hydrocortisone) _____ Antibiotic Ointment (Triple antibiotic) _____ Cough Drops

_____ Other _____

_____ 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