PARENT PERMISSION FOR THE ADMINISTRATION OF OVER-THE-COUNTER MEDICATION MIDDLE SCHOOL POLICY (GRADE 6 & 7)

WISCONSIN RAPIDS PUBLIC SCHOOLS

Student Name: _____

Date of Birth: _____

Any known food or drug allergies: _____

Grade: _____

I GIVE PERMISSION FOR THE FOLLOWING MEDICATION TO BE GIVEN TO MY CHILD BY DESIGNATED SCHOOL PERSONNEL:

Please ***check*** all that apply.

_____	Acetaminophen (Tylenol)	325 mg. or 500 mg tablet	1-2 every 4-6 hours
_____	Ibuprofen (Motrin)	200 mg. tablet	1-2 every 4-6 hours
_____	Other_____	____ tablet	_____
	Specify Medication (parent must provide)		Dose Time

_____Antacids (TUMS)	_____Triple Antibiotic Ointment
_____Topical Caladryl/Benadryl	_____Sunscreen

Parent will be responsible for providing the medication

MEDICATION CAN BE GIVEN FOR THE FOLLOWING CONDITIONS:

Please ***check*** all that apply.

_____	Headache	_____	Common Cold Symptoms
_____	Mild Muscular Skeletal Pain	_____	Sore Throat
_____	Menstrual Cramps	_____	Other

_____
Specify Other

THIS ORDER WILL BE IN EFFECT FOR THE CURRENT SCHOOL YEAR

Parent Signature_____ **Date**_____

Home Phone: _____ **Work Phone:**_____

Acetaminophen (Tylenol) 325/500 mg 1-2 tablets by mouth			Ibuprofen 200/400 mg			Other ______________________			Reason
Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	

PERSONS GIVING MEDICATIONS

1. Print Name: ____________________________ Initials: _________ Print Title: _______________________

2. Print Name: ____________________________ Initials: _________ Print Title: _______________________

3. Print Name: ____________________________ Initials: _________ Print Title: _______________________