PARENT PERMISSION FOR THE ADMINISTRATION OF OVER-THE-COUNTER MEDICATION PRIMARY LEVEL POLICY

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) _____ mg. tablet 1-2 every 4-6 hours

_____ Other_____ ____ tablet _____

Specify Medication 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: ________________________

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