



**PARENT PERMISSION FOR THE ADMINISTRATION
OF OVER-THE-COUNTER MEDICATION
SECONDARY 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)	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

_____ May keep in locker and self administer

_____ Antacids (TUMS)	_____ Triple Antibiotic Ointment
_____ Topical Caladryl/Benadryl	_____ Sunscreen

Parent will be responsible for providing the medication if required on a regular basis

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:** _____

