

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

Student Name: _____

Date: _____

Date of Birth: _____

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

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: _____