

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

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: _____