Permission for Non-Prescription Medication

This form must be completed by a parent/guardian in order for your child to receive over-the-counter medicine such as Tylenol, Ibuprofen, Benadryl, etc. **All medication must be provided by the parent.** Medication is stored in the office with your child's name labeled on each container. At the end of the school year you must pick up your child's medicine or it will be properly disposed of.

High School and Middle School students that carry an inhaler or an EPI-PEN are required to have a "Permission to Carry " form on file that MUST BE signed by a physician. Forms are available in the office.

Child's Name: _____ **Name of Medication:** _____

Dosage: _____ When/How often to give: _____

Symptoms: _____

Time frame: as needed through May 2024 ____ as needed for period of time indicated: _____

Child's Name: _____ **Name of Medication:** _____

Dosage: _____ When/How often to give: _____

Symptoms: _____

Time frame: as needed through May 2024 _____ as needed for period of time indicated: _____

Child's Name: _____ **Name of Medication:** _____

Dosage: _____ When/How often to give: _____

Symptoms: _____

Time frame: as needed through May 2024 _____ as needed for period of time indicated: _____

Parent's Signature/Phone Number: _____ Date: _____

Doctor's Name/Phone Number: _____

Permission for Non-Prescription Medication

This form must be completed by a parent/guardian in order for your child to receive over-the-counter medicine such as Tylenol, Ibuprofen, Benadryl, etc. **All medication must be provided by the parent.** Medication is stored in the office with your child's name labeled on each container. At the end of the school year you must pick up your child's medicine or it will be properly disposed of.

High School and Middle School students that carry an inhaler or an EPI-PEN are required to have a "Permission to Carry " form on file that MUST BE signed by a physician. Forms are available in the office.

Child's Name: _____ **Name of Medication:** _____

Dosage: _____ When/How often to give: _____

Symptoms: _____

Time frame: as needed through May 2024_____ as needed for period of time indicated: _____

Child's Name: _____ **Name of Medication:** _____

Dosage: _____ When/How often to give: _____

Symptoms: _____

Time frame: as needed through May 2024_____ as needed for period of time indicated: _____

Child's Name: _____ **Name of Medication:** _____

Dosage: _____ When/How often to give: _____

Symptoms: _____

Time frame: as needed through May 2024_____ as needed for period of time indicated: _____

Parent's Signature/Phone Number: _____ Date: _____

Doctor's Name/Phone Number: _____