FOR ALL STUDENTS

Non Prescription (Over the Counter) Medication
Permission for Administration to Student

I give permission to the district health office staff or health office delegate to administer the following (in accordance to medication label instructions and dosing):

☐ Acetaminophen (ie: Tylenol)
   ____ Adult Formula   ____Children’s Formula

☐ Ibuprofen (ie: Advil)
   ____Adult Formula   ____Children’s Formula

*Other specific instructions:________________________________________________________

to my child, ______________________________ , in the event he/she requires over the counter pain relief while at school.

My child gets frequent:
☐ Headaches
☐ Growing pains
☐ Sore muscles
☐ Menstrual Cramps
☐ Other:________________________________________________________

This permission is valid for the current school year only.

For elementary age students, the health office staff or delegates will take measures to inform the caregiver, by note home in student folder or phone call, when over the counter non-prescription medication (as permitted above) is given to the student.

PARENT/GUARDIAN SIGNATURE:__________________________________ DATE: ________________
WORK PHONE: ___________________________ HOME/CELL PHONE: _______________________