Administration of Over-the-Counter Medication Form

Student's name _____ Birth date _____

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

Physician to complete dosage and time/frequency

Over-the-counter medication	Circle		Dosage	Time/Frequency
Parent/Guardian to complete			**Physician to complete**	
Acetaminophen (Tylenol) for headache, toothache, or minor pain	yes	no		
Ibuprofen for headache, toothache, minor pain, or menstrual cramps	yes	no		
Anti-itch cream or lotion	yes	no		
Cough drops	yes	no		
Tums (antacid)	yes	no		

Is student allergic to any medications? ___ No ___ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's provider (Physician, Nurse Practitioner, Dentist) who completed dosage and frequency above.

Provider's signature _____ Date _____

Provider's name _____ Emergency Phone # _____

As the parent or guardian of this student, I give permission for a designee of The Ethel Streit School to administer the above medications for comfort measures. I further agree to indemnify or hold harmless any designee of The Ethel Streit School from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

Name of parent/guardian _____

Signature of parent/guardian _____ Date _____

Daytime phone number _____