



Helping students become the fully functional persons God created them to be.

Over-the-Counter Medication Guardian/Parent Authorization

STUDENT INFORMATION

Student's Name _____

Grade _____ Teacher _____ School Year _____

List any known drug allergies / reactions _____

Height (inches) _____ Weight (lbs) _____

Over-the-Counter Medication

Medication that may be administered:

_____ Tylenol _____ Benedryl

_____ Ibuprofen _____ Midol

_____ Pepto-Bismol _____ Other _____

_____ Cough Medicine _____ Other _____

I authorize the Director to delegate to school personnel the task of assisting

_____ in taking the above medication.

Parent/Guardian Authorization

Date