



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