

Non-Prescription Medication Authorization

Over-the-Counter medication will be given by the school nurse or office personnel at parent's request

Family Name _____

Please administer the following medicine, as needed, for my child. Maximum once/day.

Signature: _____ Date _____

Child's Name	Age	Check those that apply:		
		Acetaminophen	Ibuprofen	Tums
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____