



****FES/FIS PARENT PERMISSION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS****

I hereby permit:

_____ The school nurse, or other designated personnel, to give medication to my child.

*****Medication must be provided and brought to school in the original labeled container by parent. The medication should be labeled with the student's full name.*****

(Please print except for signature)

Date: _____

Student's Name: _____

Grade _____ **Date of Birth** _____

Name of Medication(Circle **ONE ONLY** or fill in other). Please fill out a form for every medication needed:

Tylenol®/Acetaminophen Ibuprofen Benadryl Motrin® Midol®

Other(Be Specific): _____

Desired dosage if less than recommended dose on bottle: _____

***Students will not receive dosage greater than recommended dose without physician's orders**

Specific request of time and directions (if any): _____

I release school personnel from liability in the event any reaction results from the named medication.

Signature of Parent/Guardian Date

Daytime Telephone of Parent/Guardian

Signature of School Nurse/Health Aide Date

****This permission expires at the end of the current school year.****
****For the safety of your student and all students, no medication should be transported by the student.****