FOLEY PUBLIC SCHOOLS
I.S.D. #51, Foley Public Schools
Foley, MN 56329

FHS 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.

_____ My son/daughter permission to possess and administer his/her own non-prescription relief medication if used according to label instructions. This permission only includes over-the-counter medications.

*****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.****