PERMISSION FOR OTC MEDICATION

Elementary School

Allergies_____ TEACHER _____

GRADE _____

STUDENT _____ Date of Birth _____

LAST FIRST MIDDLE MONTH / DAY / YEAR

ADDRESS _____ **AGE** _____

STREET CITY STATE

The above named student has my permission to take the following over-the-counter medication(s) that **we, the parents, have provided.**

ALL MEDICATION MUST BE IN ITS ORIGINAL CONTAINER AND BE APPROPRIATE FOR THE CHILD'S AGE AND SIZE. MEDICATION WILL BE GIVEN ACCORDING TO THE DIRECTIONS ON THE CONTAINER. Medication that is not age appropriate will require a HOLD HARMLESS FORM signed by a physician.

THIS CARD MUST BE RENEWED AT THE START OF EVERY SCHOOL YEAR.

LIST MEDICATIONS PROVIDED:

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

_____ _____

Signature of Parent / Guardian Date