Please complete and return to the High School Office - Thank you!

PARENT PERMISSION FOR THE ADMINISTRATION
OF OVER-THE-COUNTER MEDICATION
TOMAHAWK HIGH SCHOOL POLICY (GRADES 9TH-12TH)

Student Name:_____ Grade:_____

Date of Birth:_____

Any known food or drug allergies:_____

I GIVE PERMISSION FOR THE FOLLOWING MEDICATION TO BE GIVEN TO MY CHILD BY DESIGNATED SCHOOL PERSONNEL:

Please check all that apply:

_____ Acetaminophen (Tylenol), 325 mg tablet, 1-2 every 4-6 hours

_____ Ibuprofen (Motrin), 200 mg tablet, 1-2 every 4-6 hours

_____ Midol, 2 caplets, 2 every 6 hours

_____ Antacids (Tums)

_____ Topical Caladryl/Calamine

_____ Triple Antibiotic Ointment

_____ Hydrocortisone Cream 1% (Cortaid Itch Relief)

MEDICATION CAN BE GIVEN FOR THE FOLLOWING CONDITIONS:

_____ Headache

_____ Mild Musculoskeletal Pain

_____ Dental Pain

_____ Indigestion/Heartburn

_____ Cuts/Abrasions

_____ Common Cold Symptoms

_____ Sore Throat

_____ Rash

_____ Bug Bites

_____ Menstrual Cramps

_____ Other:_____

THIS ORDER WILL BE IN EFFECT FOR THE CURRENT SCHOOL YEAR

Parent Signature:_____ Date:_____

Home Phone:_____ Work Phone:_____