PARENT PERMISSION FOR THE ADMINISTRATION
OF OVER-THE-COUNTER MEDICATION
TOMAHAWK ELEMENTARY SCHOOL POLICY (GRADES 4k-5TH)

Student Name: ____
Date of Birth: ____
Any known food or drug allergies: _________________________________
Grade: ______________________

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

Please **check** all the apply.

	Medication	Dose
________	Acetaminophen (Tylenol) Children's Liquid	Dose per Child's Weight
________	Acetaminophen (Tylenol) Children's Chewable	Dose Per Child's Weight
________	Acetaminophen (Tylenol) Junior Chewable	Dose Per Child's Weight
________	Acetaminophen (Tylenol) 325 mg Tablet	1 every 4-6 hours
________	Ibuprofen (Motrin) Children's Liquid	Dose Per Child's Weight
________	Ibuprofen (Motrin) Junior Chewable	Dose Per Child's Weight
________	Ibuprofen (Motrin) 200 mg. tablet	1 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 Muscular Skeletal Pain
______ Dental Pain
______ Indigestion/Heartburn
______ Cuts/Abrasions

______ Common cold Symptoms
______ Sore Throat
_______ Rash
_______ Bug Bites
_______ Other
____
(Specify other)

THIS ORDER WILL BE IN EFFECT FOR THE CURRENT SCHOOL YEAR

Parent Signature:_____________________________ **Date:**_____________________
Home Phone: ____________________________ **Work Phone:**______________