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

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.

_____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)	_____ Triple Antibiotic Ointment
_____ Topical Caladryl/Calamine	_____ Hydrocortisone Cream 1% (Cortaid Itch Relief)

MEDICATION CAN BE GIVEN FOR THE FOLLOWING CONDITIONS:

_____ Headache	_____ Common cold Symptoms
_____ Mild Muscular Skeletal Pain	_____ Sore Throat
_____ Dental Pain	_____ Rash
_____ Indigestion/Heartburn	_____ Bug Bites
_____ Cuts/Abrasions	_____ Menstrual Cramps
_____Other	_____ (Specify Other)

THIS ORDER WILL BE IN EFFECT FOR THE CURRENT SCHOOL YEAR

Parent Signature:_____ **Date:**_____
Home Phone: _____ **Work Phone:**_____