PARENT PERMISSION FOR THE ADMINISTRATION
OF OVER-THE-COUNTER MEDICATION
TOMAHAWK MIDDLE SCHOOL POLICY (GRADES 6TH-8TH)

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
______ Mild Muscular Skeletal Pain
_____ Dental Pain
_____ Indigestion/Heartburn
_____ Cuts/Abrasions
_____Other

_____ Common cold Symptoms
_____ Sore Throat
______ Rash
______ Bug Bites
______ Menstrual Cramps

____
(Specify Other)

THIS ORDER WILL BE IN EFFECT FOR THE CURRENT SCHOOL YEAR

Parent Signature:____________________________ **Date:**_____________________

Home Phone: ___________________________ **Work Phone:**_____________