

USD 263 Mulvane School District

OTC MEDICATION PERMISSION FORM

Student Name: _____

OVER-THE-COUNTER (OTC) MEDICATION ONLY

Will you permit school health office personnel to administer the following medication(s), as needed, to your student for minor discomfort or injury?

Acetaminophen (Tylenol)	Yes	No
Ibuprofen (Advil/Motrin)	Yes	No
Antacid (Tums)	Yes	No
Antihistamine (Benadryl/diphenhydramine, Zyrtec/cetirizine)	Yes	No

Medications supplied by the school may vary between buildings and grade levels. **Should your student need these medications regularly or often, you will be asked to send your medication to the health office for your student.**

This form will be effective for this school year only and will be resubmitted each school year. If you would like to make changes to your responses during the school year, please contact your student's health room. *All prescription medications will have a separate form that will need to be filled out by the parent/guardian.*

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____