BURLINGTON COMMUNITY SCHOOL DISTRICT
OVER THE COUNTER MEDICATION (OTC)
PERMISSION FORM

I am the parent/Guardian/custodian of:

Student's Name:____

Grade:_______________ School:______________________________________ Date of Birth:________________

I request and authorize school personnel to administer the following medication to my child:

Name of Medication: Tylenol, Tums, Ibuprofen, Cough drops, Other (specify):

____

Dosage: _As Directed_ ____

Time: _As Needed_ ____

Route of administration: _As Directed____

Start date: ________________________________ End date: End of School Year_______________

Reason medication is being given: ____

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Special Directions and Signs or Side Effects to Observe: ______________________________________

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Instructions: Cross off any medication you do not wish given to your child. List any additional OTC Medications your child may need (parent provided) (i.e. allergy, cough, cold, Midol, etc.)

____ ______________________________
(Parent's signature) (Date)

If you have questions, please contact the school nurse at your child's building.