Parent's Request for Administration of Medication by School Personnel

I hereby request and give authorization to the school clinic, school principal, or other delegate to administer the following over the counter medication *(e.g., Ibuprofen, Acetaminophen, Benadryl, Cough drops, Cough syrup)* to my child.

Student's Full Name:_____

Name of Medication:_____

Dose:_____ Route:_____

Time(s) to administer:_____

Signature of Parent/Guardian:_____

Date:_____