## Medication Permission

Student Name: _____ Birthdate: _____

Parent phone number(s) during the day: _____

Medication this student takes daily/regularly: _____

Medical concerns: _____

Allergies: _____

We prefer that families send their own medication for use. Listed below are temporary medications available at school if an illness should arise. **Clearly cross through any medication(s) your child is NOT allowed to have.** Please sign below if you give permission for your child to receive the following as needed.

| | | |
|---|---|---|
| **Tylenol or Generic Acetaminophen** | **Advil or Generic Ibuprofen (will NOT be given to a child with a diagnosis of asthma)** | **Cough drops, including menthol** |
| **Tums (antacids)** | **Benadryl** | **Hydrocortisone Cream** |
| **Neosporin** | **Hydrogen Peroxide** | **Vaseline** |
| **After-Bite** | **Visine** | **Cetaphil** |

Parent Signature: _____ Date: _____

| Date: | Time: | Medication: | Reason: | Given By: |
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