

OVER THE COUNTER MEDICATION POLICY FORM

TO ALL PARENTS OR GUARDIANS:

Please complete the Over the Counter Medication Policy Form below.

IT IS IMPERATIVE THAT WE RECEIVE A FORM FOR EACH CHILD REGISTERED IN OUR SCHOOLS.

____ Yes, I give the school nurse permission to administer the following over the counter medications as needed: Ibuprofen, Tylenol, Benadryl, and an antacid, as well as throat lozenges.

____ No, I **do not** wish the nurse to administer any over the counter medications to my child.

Please answer the following questions regarding your child:

Child's Name _____ Classroom # _____

Allergies _____

Medical Problems _____

Medication Taken _____

Other information regarding your child you would like the School Nurse and/or School Department Employees to know _____

Please be informed that the above information will be shared with Pawtucket School Employees as needed.

Signature of Parent/Guardian _____ Date _____