

Over-the-Counter Medication Form

Date: _____ **Student Name:** _____ **Student Grade:** _____
Student Date of Birth: _____ **Student Program:** _____

My child may be administered the following Over-the-Counter medications supplied by SCCTC:
I hereby grant permission for Springfield-Clark CTC to dispense the medication(s) indicated below to the above named student. I understand that the school nurse will make the final determination for administering these medications. I understand that on occasion, non-medical personnel may administer medications.

Parent/Guardian Name: _____ **Signature:** _____ **Phone:** _____ **Date:** _____

- Yes** **No** **Acetaminophen (Tylenol) 325 mg/tab, 2 tablets**
- Yes** **No** **Ibuprofen (Advil) 200 mg/tab, 2 tablets**
- Yes** **No** **Pepto Bismuth (Pepto Bismol) 262 mg/tab, 2 chewable tablets or the liquid equivalent**
- Yes** **No** **Anti-Acid (Tums), 2 chewable tablets**
- Yes** **No** **Cough Drops as needed**

SCCTC reserves the right to remove any of the above Over-the-Counter Medications from availability.

**This form and any accompanying medication should be turned in to the school nurse upon arrival at school.
 Parents may fax this form to: (937-325-3990) or email to: brendalovelace@springfieldclarkctc.org**

ADDITIONAL Over-the-Counter Medication provided by Parent/Guardian:
As the Parent/Guardian, I have supplied the following Over-the-Counter medication for my child to take as needed and as directed below, which is within the manufacturer's dosing recommendations. I have supplied the medication in its original container and have marked my child's name on it. I understand that I am responsible for picking up left over medication at the end of the school year or the medication will be discarded.

Name of Medication: _____

Dosage and Directions: _____

Parent/Guardian Name: _____ **Signature:** _____ **Phone:** _____ **Date:** _____