RIDGECROFT SCHOOL

Reguest for Over the Counter Medication to be given During School Hours

To be Complete by Parent/Guardian:

Name of Student _____

Please Check all that apply:

_____ Ibuprofen _____ Tylenol _____ Motrin
_____ Antacid _____ Cough Drop _____ Other _____
_____ Inhaler Can it be carried by student? _____Yes _____No

Dosage: _____

Time(s) medication is to be give:_____am _____pm

This medication will be furnished by parent or guardian, in their original container.
All medications will be located at the Administrative Office in a locked file cabinet.

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours.
I hereby release the School Board and their agents and employees from all liability that may result from my child taking the over the counter medication.

_____ _____ _____
Parent or Guardian's Signature Telephone Number Date