SCHOOL MEDICATION PERMISSION AND INSTRUCTIONS

Over-The-Counter-Medication

PARENT/GUARDIAN PERMISSION

Student's Name:______________________________

Birth Date: ____________________

Address: ______________________________

City: ____________________

School: **Franklin Monroe Schools**

Grade: __________

I am requesting permission for my child named above to use or receive medication.
I will notify the school immediately if there is any change in the use of the medication.
I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Medication (circle choices): Tylenol(325mg) Advil(200mg) cough drops hydrocortisone cream

Circle Dose: 1 or 2 pills 1 or 2 pills eye drops burn gel Neosporin

Reason for use (optional)/ or other medication not listed:

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Parent/Guardian Signature

______________________________ ______________________________
Home/Cell Phone Work Phone

Prescription
PRN

DATE	TIME	COMPLAINT	ASSESSMENT	STAFF SIGNATURE