PERMISSION TO ADMINISTER OVER THE COUNTER STOCK MEDICATIONS

Student Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____School: _____

PLEASE LIST ALL MEDICATION ALLERGIES.

1. _____
2. _____
3. _____

List all medication your child takes on a routine basis:

Name of Medication	Dosage	Times to be taken	Purpose

List below any additional health information that the staff should be aware of:

_____

_____

Health Activity Fee Received: _____Yes _____No

1) Please check **all** the boxes below of the over the counter stock medication that your child **may have** during the school day or when participating in school activities or trips
2) Please list the symptoms for which each medication may be given.

Check	Medication	Symptoms for which medication may be used
	Ibuprofen	
	Acetaminophen	
	Antibiotic Ointment	
	1 % Hydrocortisone Ointment	
	Burn gel	
	Anti-itch spray	
	Cough Drops	
	Antacid Tablet (chewable)	

I, the undersigned parent/guardian hereby givs permission to GCS school staff to administer the checked medications according to manufacturers recommendations to my child. I will notify the school nurse of any medications that are given prior to their arrival at school. I also release the Greeneville City School System and its personnel from any legal claim they now have or may thereafter have arising from the administration of or failure to administer medication to the student. I will assume full responsibility for any side effects and complications that my child may have as a result of medications.

Parent/Guardian Signature: _____Date_____