OTC MEDICINE REQUEST FORM

Student Name _____

Grade _____ DOB _____

Students Age_____Weight_____

Name of Medication TYLENOL, IBUPROFEN, BENADRYL_____

(We have children's and adults doses available.) **Dosage will be based on child's age and weight.**

____Yes, you may give my child Tylenol or acetaminophen.
____Yes, you may give my child Ibuprofen
____ Yes, you may give my child Benadryl for an emergency allergic reaction *(bee sting, food allergy, etc).*
____Do not give my child medication.
____Please call me before giving medication.

Preferred contact number _____

Parent/Guardian Name _____

Parent/ Guardian Signature _____ Date _____

Notary Signature_____Date _____

Commission Expires_____

RECORD OF DISTRIBUTION

Date	Time	Dose	Given By