Request for Over the Counter Medication Administration

The parent/guardian of _____ requests that The Samuel School
(Student Name)
staff administer the medications selected below as needed. It is the parent/guardian's responsibility to furnish OTC (over the counter) medication. Regular Tylenol (not Children's) will be available for students with permission from parents/guardians. The parent agrees to pick up expired or unused medication within one week of notification by staff. **Over the counter medication** must be labeled with child's name. **Dosage must match package labeling and the medicine must be packaged in its original container. Please make sure student's name is clearly marked on the container.**

- ☐ Ibuprofen
- ☐ Tylenol
- ☐ Benadryl
- ☐ Cough Drop
- ☐ Antibiotic/Ointment
- ☐ Other _____

By signing this document, I give permission forThe Samuel School staff to administer OTC (over the counter) medication to the above named child.

Parent/Legal Guardian's Name _____

Parent/Legal Guardian's Signature _____

Date _____

Work Phone _____Home Phone_____ Cell Phone_____

Office Use Only:

Date Medication Received _____ Medication Received by _____

Date Completed Form Received _____ Completed Form Received by_____