Permission to Administer Over-the-Counter Medications and Food Allergy Information

I/We the undersigned parent(s) or legal guardian(s) of __________________________ (the "student") hereby authorize and request school personnel to administer the over-the-counter medications marked below to the student as is deemed reasonably necessary and appropriate.

____ Cough drops

____ Pain relievers such as Ibuprofen, Acetaminophen, Aspirin

____ First aid ointments

Check all that apply:

___ Such medications will be provided by the parent/legal guardian

___ School personnel may provide these over-the counter medications

- Students are not to keep medications with their personal belongings.
- All medications are to be kept by school personnel.

Please list any food allergies your child has (NOT food preferences):
____
____

___________ ____
Date Parent/Guardian

___________ ____
Date Parent/Guardian

February 2, 2020