DAYTON INDEPENDENT SCHOOLS

Authorization for Administration of Over-the-Counter Medication at School
NOTE: This form agreement expires at the end of each school year.

_____ _____
Student Name Date of Birth

_____ _____ _____
School Grade School Year

Circle yes or no to all that apply. If your child is allergic to any of these medications, please mark below.

Over-the-Counter Medication	Circle One		
Acetaminophen (Tylenol) for headaches	Yes	No	Allergic
Acetaminophen (Tylenol) for toothache or minor pain	Yes	No	Allergic
Ibuprofen for menstrual cramps	Yes	No	Allergic
Ibuprofen for headache, toothache, or minor pain	Yes	No	Allergic
Anti-itch cream or lotion	Yes	No	Allergic
Cough Drops	Yes	No	Allergic
Tums (antacid)	Yes	No	Allergic

I give permission to the school nurse or Dayton Independent School designee to give my child the above-mentioned medications for comfort measures during school hours or during after-school activities. I further agree to indemnify or hold harmless the Dayton Independent Schools and agents from all claims as a result of any and all acts performed under this authority.

_____ _____
Signature of Parent/Guardian Date

_____
Parent/Guardian Name (Please Print)

How can we reach you during school hours?

_____ _____ _____
Work Phone Home Phone Cell Phone

NOTE: If your child has a chronic medical condition; such as diabetes, severe allergies, migraines, or sickle cell anemia; please have your child's physician complete and sign an individual medication form – obtained from the school nurse's office.