

Scattergood Friends School

Parental Permission for OTC Medication Administration

I(We), Parent(s)/Guardian(s) of _____, a student at Scattergood Friends School, give permission for licensed and/or certified Staff to administer the following over-the-counter medication(s) to my child upon my child's request and supporting assessment of need. I have designated each medication and understand the use, dosage, and potential side effects. This permission shall be in effect as long as my child is a student at Scattergood Friends School, and may be rescinded and/or modified by me at any time upon my written request.

- _____ Ibuprofen (Motrin)
- _____ Acetaminophen (Tylenol)
- _____ Naproxyn Sodium (Aleve)
- _____ Excedrin
- _____ Diphenhydramine HCl (Benadryl)
- _____ Loratadine (Claritin)
- _____ Bismuth Tablets (Pepto-Bismol)
- _____ Loperamide HCl (Lomotil)
- _____ Milk of Magnesia
- _____ Lactase Enzyme
- _____ Other _____
- _____ Other _____
- _____ Other _____
- _____ Other _____

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date