

**OUR COMMUNITY SCHOOL
OVER-THE-COUNTER MEDICATION PERMISSION SLIP**

Name: _____ Age: _____ Allergies: _____

I hereby authorize the staff of Our Community School to administer the following **over-the-counter medication** to my child, as needed.

___ Acetaminophen	___ Calamine Lotion
___ Ibuprofen	___ Decongestant
___ Cough Syrup	___ Other _____
___ Throat Lozenges	___ Other _____

Note: All over-the-counter medications must be submitted to the school office with your child's name on it. Please check expiration date and age recommendations on the bottle. The school will not exceed recommended dosage or administer medication if age recommended does not match your child's age.

Parent Signature

Date

**OUR COMMUNITY SCHOOL
PRESCRIPTION MEDICATION SLIP**

Name: _____ Age: _____ Allergies: _____

I hereby authorize the staff of Our Community School to administer the following **prescription medication** to my child at the designated time.

Medication: _____ Dosage: _____ Time: _____

Needs to be refrigerated: ___ yes ___ no

Please administer medication:

From _____ Through _____ Until _____ Today only _____

Note: Prescription medication needs to be in a prescription bottle with the child's name on it. The school will administer the medication only within the time frame specified on the prescription bottle.

Parent Signature

Date