Permission for Administration of Over-the-Counter Medication for Urbandale High School and Urbandale Middle School Students

I request and authorize school personnel to administer the following recommended nonprescription medication, in the manufacturer's recommended dose, when the school nurse deems it appropriate (not to exceed six separate administrations each school year).

_________ **Ibuprofen** (Advil/Motrin) _________ **Acetaminophen** (Tylenol)

Student__________________________________ **Birthdate**________ **Grade**______

Signature of Parent/Guardian_____________________________________Date____________