

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

Student _____ Birthdate _____ Grade _____
(Please Print)

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)

Please mark one or both types of medication.

My signature below indicates that the information for Over-the-Counter Medication is factually correct and complete.

Parent/Guardian (signature) _____ Date _____

* * * * *

Record of OTC Medication Administration

	Date	Time	Medication	Dosage	Reason	Initials
1)						
2)						
3)						
4)						
5)						
6)						

Nurse/medication administrator:

Signature _____ Title _____ Initials _____

Signature _____ Title _____ Initials _____