School Year_____

TCC OVER THE COUNTER MEDICATION AUTHORIZATION FORM

Student Name_____ Date of Birth_____

Allergies_____

Medical History_____

ALL MEDICATIONS REQUIRE A PARENT SIGNATURE

I hereby request and give permission to the principal or his/her designee (school nurse or other responsible adult) to supervise my child as he/she takes the below noted medication(s). I release the school from any and all liability for damages or injury resulting directly or indirectly from the presence of medication in the school or its use by my child. All medications will be administered per school medication policy. I also authorize the exchange of information between the health care provider and school personnel regarding this medication when deemed necessary.

Mark clearly your wishes for your child regarding each of the medications listed below. These medications will be provided by TCC. This authorization form applies to current school year.

YES	NO	MEDICATION
___	___	**Tylenol 325 mg 1-2 tabs by mouth every 4-6 hours as needed for pain**
___	___	**Advil 200 mg 1-2 tabs by mouth every 6-8 hours as needed for pain**
___	___	**Cough drops 1 by mouth every 2 hours as needed for cough**
___	___	**Tums 1-2 tabs by mouth up to 3 times daily as needed for gastric upset**
___	___	**Benadryl 25 mg 1 tab by mouth every 4-6 hours as needed for allergies**

PARENT/GUARDIAN:

Signature_____ Relationship_____ Date_____

Phone (Home)_____(Work)_____ (Cell)_____