Rogers Adventist School

2010-2011

ADMINISTRATION OF OVER-THE-COUNTER MEDICATION

Students' Name: _____

Medicine Available: ❑ Yes ❑ No **Tylenol** ❑ Yes ❑ No **Advil**

Dosage & Frequency: **As directed on medication for age level**

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the above named school to administer the above identified medication to the above identified student during the 2010-2011 school year.

Home Phone: _____ Other: _____

Dad's Work: _____ Dad's Cell: _____

Mom's Work: _____ Mom's Cell: _____

_____ _____

Signature Date

DISPENSING RECORD

Date	Time	Medication Name	Dose	Initials