LOWER CAPE MAY REGIONAL SCHOOL DISTRICT – Medication Administration Record

Over the Counter Medication Form (School Year _____)

I request that (student name): _____ Grade _____ ID# _____

Receives the following medication(s) (circle any permitted):

ANY NEEDED Ibuprofen/Motrin Acetaminophen/Tylenol Antacid/Tums Other: _____

Allergies or medications your child SHOULD NOT TAKE: _____

Comments: _____

Parent/Guardian Signature_____ Date_____

- Absolutely NO medications will be given without WRITTEN parent/guardian PERMISSION.
- **MEDICATIONS must be SUPPLIED FROM HOME in original bottle.**
- Medications MUST be kept in nurse's office.

	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sep																															
Oct																															
Nov																															
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Feb																															
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Apr																															
May																															
Jun																															

Nurse's Signature: _____ _____

_____ _____

* **Authorizations are effective for one school year only and must be renewed annually.**