NOTRE DAME ACADEMY

A Sisters of Union-Chrétienne de Saint Chaumond School

Medication Authorization Form
2017-2018

Part I

Authorization for Selected Over-The-Counter Medication with Parental Approval Only

Student Name: _____ Grade: _____ Birth Date: _____

Medication	Does your child have permission to receive this medication at school? (circle yes or no)	Dosage (please indicate the dosage your child should be administered at school)	Additional Comments
Acetaminophen (Tylenol)	YES NO		
Ibuprofen (Advil, Motrin)	YES NO		
Calcium Carbonate (Tums)	YES NO		
Throat Lozenges / Cough Drops	YES NO		
Benadryl Cream	YES NO		

PART II

Authorization for other medication that you might be providing (prescriptions, inhalers, etc.)

Medication (please name the medications)	Does your child have permission to receive this medication at school? (circle yes or no)	Dosage (please indicate the dosage your child should be administered at school)	Additional Comments
	YES NO		
	YES NO		

PART III

Parent Authorization

Name of Parent/Guardian (please print): _____

Signature of Parent/Guardian: _____

Relationship to Student: _____ Phone Number: _____