OVER-THE-COUNTER MEDICATION

CHRISTIAN UNIFIED SCHOOLS OF SAN DIEGO

DATE	STUDENT NAME	GRADE

I give permission for the school nurse or designated school personnel to administer the following indicated over-the-counter medication(s) to my child for the listed complaints.

MEDICATION	FOR THE COMPLAINT OF	AMOUNT	FREQUENCY

ADDITIONAL INSTRUCTIONS:

PARENT SIGNATURE: _____

PARENT NAME (PRINT): _____