Request for Over the Counter Medication Administration

2020-2021 School Year

The parent/guardian of _____ gives permission for a
(Child's Name)
Dayspring Christian Academy staff member to administer the medications listed below as needed.

For **students over 12 years of age**, the following medications are provided by DCA. Please check the box(es) indicting which medications our staff may administer if /when your child may need it.

☐ Ibuprofen (200 mg) ☐ Tums Antacid ☐ Cough Drops ☐ Regular Tylenol (325 mg)

For **students in Kindergarten thru 5th grade**, it is the parent/guardian's responsibility to furnish OTC medication.

All over the counter medication must be labeled with child's name. **Dosage must match package labeling and the medicine *must be packaged in its original container*. Please make sure student's name is clearly marked on the container.**

Special Instructions: _____

_____

Please list all OTC medications sent to school:

_____ _____

_____ _____

The following is a list of medications provided by DCA for **all students**. Please check the box(es) indicting which medications our staff may administer if /when your child may need it.

☐ Aloe Vera Gel ☐ Benadryl Spray ☐ Calamine Plus ☐ Neosporin Ointment

By signing this document, I give permission for Dayspring Christian Academy school staff to administer OTC (over the counter) medication to the above named child.

Parent/Legal Guardian's Name _____

Parent/Legal Guardian's Signature _____

Date _____

Work Phone _____Home Phone_____ Cell Phone_____

Office Use Only:

Date Medication Received _____ Medication Received by _____

Date Completed Form Received _____ Completed Form Received by _____