Taylor Chapel Academy Record of Over the Counter Mediation

This form expires at the end of the current school year

_____ School Year

Child's Name: _____

D.O.B. _____

Address: _____

As the parent/guardian, I give permission for my child to receive the following over the counter medications while in the care of Taylor Chapel Academy. I agree to provide the medication my child needs in the original container.

If a student has an allergy to medications this form must be signed by a health care provider and have the correct dosage and frequency listed above by said health care professional

Over the Counter Medications			Dosage	Frequency
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No		
Ibuprofen for headache, toothache or minor pain	Yes	No		
Anti-Itch cream sunscreens or lotions	Yes	No		
Antihistamines (Benadryl)	Yes	No		
Cough drops	Yes	No		

Is student allergic to any medications? ☐ No ☐ Yes, allergy to: _____

Severe reactions that should be reported: _____

_____

Provider's Signature: _____ Date: _____

Provider's Name: _____ Phone Number: _____

I give permission for Taylor Chapel Academy staff to administer, with witness, the approved medications above for comfort measures. I further agree to hold Taylor Chapel Academy and its staff harmless from all claims as a result of the approved medication administration.

Parent/Guardian Signature: _____ Date: _____

Please Print Name of Parent/Guardian: _____

How can we reach you during operational hours?

_____ Work Phone _____ Cell Phone _____ Home Phone _____ Other