

Dominion Academy
2024-25 Academic Year

OVER THE COUNTER MEDICATION FORM

Student Name: _____ Grade: _____

Over-the-counter medications are those that do not require a prescription. This form is required before such medications can be administered at school.

The medications listed below are kept on hand in the school office. **I give permission for the following medication to be given to my student** (please initial):

____ Ibuprofen

____ Acetaminophen

____ Benadryl

____ Other (Any medication not listed above *must be provided to the school* by a parent in an unopened, original container, clearly labeled with the student's name, grade, and the school year.)

Name of medication: _____

Use if student has these symptoms (i.e., stomachache):

Medications will be given at the manufacturer's recommended dosage.

____ I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization. (Please initial.)

____ I understand that by signing and giving written permission to administer over the counter medications to my child I will still be contacted for verbal permission before any medications will be given. (Please initial.)

Signature of Parent or Guardian

Date

Phone number for Parent or Guardian

