Marie Philip School - Residential

**Over-the-counter Medication Permission**

**2018-2019**

Student name: Date of Birth:

Last, First, Middle name

The following over the counter medications will be given to your child if the need arises, with both parent/guardian permission and an MD’s order.

I give permission for my child to receive the medications listed below during the school year. I have checked **NO** for any medications or creams that I do **NOT** give permission for my child to receive.

**TYLENOL** Yes **❑** No **❑**

**ROBITUSSIN** Yes **❑** No **❑**

**BACITRACIN OINTMENT** Yes **❑** No **❑**

**TUMS** Yes **❑** No **❑**

**SUNBLOCK** Yes **❑** No **❑**

**ADVIL** Yes **❑** No **❑**

**COUGH DROPS** Yes **❑** No **❑**

**MUSCLE RUB (i.e., Bengay)** Yes **❑** No **❑**

**HYDROCORTISONE CREAM** Yes **❑** No **❑**

Please indicate any other over-the-counter medications your child may need: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent/guardian signature: Date:

Student signature (if 18 or older): Date: