Marie Philip School - Residential

Over-the-counter Medication Permission

Date: ____________________

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	❑
ORAJEL	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:______________