NAME _____ GRADE _____ (Home Room) TEACHER _____
LAST FIRST MI

TIPTON COMMUNITY SCHOOL CORPORATION
PERMISSION FOR NON-PRESCRIPTION MEDICATION

I authorize the school nurse, or other school personnel under the direction of the school nurse, to be my agent to give medications checked below to my child. Generic brands are given in most cases and medications are given only when deemed necessary. Written permission is required before any medication can be given.

My child may receive the medication(s) checked below:

____ Tylenol (chewable 80 mg)	2 tabs	Every 4 hours as needed
____ Tylenol (325 mg)	1 or 2 tabs	Every 4 hours as needed
____ Ibuprofen (200 mg)	1 or 2 tabs	Every 6 hours as needed
____ Tums	1 or 2 tabs	Every 2-4 hours as needed
____ Benadryl Syrup/Capsule	Per Package direction	Bee Sting/Allergic Rx
____ Eye Drops	1-2 drops	Every 2-4 hours as needed

____ Topical Preparations
(Bacitracin oint., Hydrocortisone Cream, Caladryl/Calamine Lotion, Dermoplast spray, OraGel, Blistex, Hydrogen Peroxide, Vaseline, Rubbing Alcohol, Hand/Body Lotion)

Parent/Guardian Signature _____ Date _____