# SCCS MEDICATION DISPENSING PERMISSION SLIP
# 2024-2025

Date: _____

Child's Name: _____

**Please indicate if SCCS has permission to administer the following over-the-counter medications (or equivalent generic) to your child.**

| | |
|---|---|
| Tylenol | Yes _____ No _____ |
| Advil | Yes _____ No _____ |
| Cough Drops | Yes _____ No _____ |
| Tums | Yes _____ No _____ |

**Other Medications:**

Name of medication: _____

Amount of medication to be administered: _____

Frequency of dosage: _____

Date of discontinuation of medication: _____

Reason medication is needed: _____

_____

Parent or guardian phone number: _____

Parent or guardian signature: _____

****All medication, prescription or over-the-counter, must be in the original container.**

****All medication, prescription or over-the-counter, must be kept in the school office.**

****Asthma inhalers and other rescue medications may be kept on the person as long as a written statement from the physician is on file in the office. (This has to be renewed each year.)**