SCCS Medication Dispensing Permission Slip
2026-2027

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: ________________________________

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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.)**