

**PLYMOUTH EDUCATIONAL CENTER**  
**Over-the-Counter Medication Authorization Form**

Student Name \_\_\_\_\_

Grade \_\_\_\_\_

Homeroom Teacher \_\_\_\_\_

Birth date \_\_\_\_\_

Listed below are "over-the-counter" medications that are available to students for administration by the School Nurse. Medication administered at school is intended to relieve symptoms until you are able to follow-up at home and/or seek medical treatment.

- Tylenol - liquid, children's chewable or regular
- Motrin (anti-inflammatory) - liquid or pill
- Benadryl - liquid or pill
- Mylanta
- Tums
- Sudafed
- Cough Syrup

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I grant permission for my child to receive the above over-the-counter medications from the School Nurse.

Parent/Guardian Signature \_\_\_\_\_

Phones: Day \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Home \_\_\_\_\_

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Do not give my child over-the-counter medication. Please inform me of any symptoms he/she may experience.

Parent/Guardian Signature \_\_\_\_\_

Phones: Day \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Home \_\_\_\_\_

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My child is allergic to the following medications:

_____	_____
_____	_____
_____	_____

My child has the following food allergies:

_____	_____
_____	_____