Salmon River Jr-Sr High School
Authorization for Administration of Over the Counter Medication

During 2018-19 school year only

I hereby give consent for my child _____
to be given upon his/her request at the discretion of the school nurse or designated authority and per package instructions. (Please check appropriate box or boxes):

- ☐ Acetaminophen
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ None

- ☐ Diphenhydramine (Antihistamine)
- ☐ Cough Drops
- ☐ Hydrocortisone Cream
- ☐ Antibiotic Ointment
- ☐ Calcium Antacid
- ☐ None

Parent/Guardian Signature _____

Today's Date:_____