HOLY CROSS CATHOLIC ACADEMY
Amarillo, Texas

Permission to allow students to take medication at school

I give permission for my son/daughter _____

To take -- Tylenol, Advil, Pepto Bismol, cough drops, eye drops, etc. _____
Parent Initials

_____ _____
Name of Medication - Prescription/Over the Counter Dose, i.e. 1 or 2 per school day

Doctor's Name:_____ Pharmacy_____

_____ I have provided the medication needed by my son/daughter.

_____ _____
Signature Parent/Guardian Date

_____ _____ _____
Home Phone Work Phone Cell Phone

Comments/Instructions_____

_____

Date taken	Dose	Staff Initials

Date taken	Dose	Staff Initials