Treynor Community School
Over the counter medications

Please list each of your children separately:

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

*Please mark only **one** of the following selections for the child(ren) named above:*

_____ The school nurse has my permission to administer over-the-counter treatments (such as Tylenol, Tums, or anti-itch cream) as needed to my child while he/she is at school.

_____ I would like the school nurse to call me before administering any over the counter medications to my child. I understand that she will not continue calling me if she is unable to reach me initially.

Signature of parent or guardian _____

Date _____