McClusky Public School Medication Consent 2020-2021

I give the certified school staff the authorization to distribute over-the-counter pain medication to my son/daughter. To the best of my knowledge my son/daughter is not allergic to these pain relievers and this will not cause any complications.

Please fill in the strength of medication and also the amount of medication that they are to be given.

☐ **Junior Strength Ibuprofen (NSAID), 100 mg (# of pills to be given):** _____

☐ **Ibuprofen (NDAID), 200 mg (# of pills to be given):** _____

_____

_____

Student Name

_____ _____

Parent/Guardian's Signature Date

**** Please note: ****

Any information for prescription medication must be filled out on a separate form and obtained through the High School Office before medication can be distributed to your child.