Burrillville Middle School

Authorization/Parental Consent for Over the Counter Medication

Student Name____Grade_____________

Advisor_______DOB______________________Allergies__________________________________

I give permission for the above named student to take the following over the counter medications during the school day. Doses will be given according to age and weight.

Please check below for preferred allowed medications:

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil)

Check here if you wish to be called each time student requests above medication. ☐
(Note that if student is requesting often, you will be notified)

Best number to reach you if needed:____

Authorization

My child listed above will be given the above medication in accordance to the Burrillville Medication Policy. I understand that the school is rendering a service, and I retain full responsibility for any effects resulting from the administration of above medication.

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Parent/Guardian Signature Date