Permission to Treat and Administer Over the Counter Medications

STUDENT NAME _____ DATE OF BIRTH _____GRADE_____

Please initial each option below if you agree.

_____I give permission for WCCS faculty, staff, and administrators to administer first aid to my child without my prior permission.

_____I give permission for WCCS faculty, staff, and administrators to administer the following over the counter medications to my child without my prior permission:

Tylenol/acetaminophen	Neosporin (for cuts/scrapes)
Advil/ibuprofen	Hydrocortisone cream
Benadryl	After Bite/Sting Relief
Vaseline	Diaper Cream (for infants/toddlers)

****Please let the WCCS School Nurse (emckinnon@wccs.org) know at morning drop-off if you gave any of these medications in the morning before school, so there is no chance of a "double dose"****

_____ _____

Signature of Parent/Guardian Date

Parent email:_____ Parent phone:_____