THE KING'S ACADEMY

1015 S. Ebenezer Road Florence, SC Phone 843. 661.7464 Fax 843. 661.7647

www.tkaflorence.com

Over- the- Counter Medication Permission Form

Student: _____DOB_____Grade_____

Teacher: _____

OTC Medication	Dosage	Frequency or time to be administered	Route of Administration

PARENTAL PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATION

I request that the school nurse or the headmaster's designee administer the over the counter medications listed above according to package dosing and instructions. I understand that I must provide any medication in the original labeled container and packaging. I will not hold the school or school nurse liable for adverse drug reactions that can occur with medication administration.

Parent/Guardian Signature:_____

Date:_____Daytime phone #_____