To be completed by ALL Parents/Guardians and returned to the school nurse.

LINCOLN SECONDARY LEVEL

Over the Counter Medication Record

Student: _____School Year: _____Grade:_____

Tylenol (Acetaminophen) Dose: Per Label/Indications: _____

Advil, Motrin (Ibuprofen) Dose: Per Label/Indications: _____

Tums Dose: Per Label/Indications: _____

The above medications are supplied by the school.

MD orders are required for Prescription or over the counter medication (not listed above). They must be sent to school in the original container.

( ) I do not want my child to have any medication during school hours.

Parent/Guardian Signature: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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