LABBB Health Office at Lexington High School
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Parent/Guardian Authorization for Over-the-Counter Medication Administration for LABBB High School Students

Student name: _____ **DOB:** _____

Parent/Guardian name: _____

Home telephone number: _____

Work telephone number: _____

Mobile telephone number: _____

Please give my student the following medication in school as indicated per school protocol:

- ☐ **Tylenol (tablet only, no liquid**
- ☐ **Ibuprofen (tablet only, no liquid)**
- ☐ **Tums (chewable)**

My student has the following allergies: _____

My student is currently taking the following medications (to be completed if not in violation of confidentiality):

_____

_____

_____

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my student's health and safety.

Parent/Guardian signature: _____ Date: _____