CHARTER SCHOOL OF EXCELLENCE

Charter School of Excellence

Student Name: _____
Grade: _____ DOB: _____
Allergies: _____
Current Medications: _____
Emergency Phone No.: _____

I, _____ (the parent/guardian of the student) hereby give my permission for the student to take the following medication(s):

Name of non-prescription medication	Dosage	Time
Ibuprofen	1-2 200 mg tablets	as needed every 6 hrs.
Tylenol	1-2 500 mg tablets	as needed every 4 hrs.
Tums	1-2 tablets	as needed every 4 hrs.
Other: _____	_____	_____

Reason for pain, headache, body aches, or indigestion/heartburn

Pursuant to this permission, I hereby release, save harmless and agree to indemnify the Charter School of Excellence and all its employees from any and all liability for damages the student may suffer as a result of this request. I also agree that the Charter School of Excellence bears no responsibility for ensuring that the medication is taken.

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____

For School Use Only

Date	Time	Given By
_____	_____	_____
_____	_____	_____
_____	_____	_____
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