Harpswell Coastal Academy

Permission to Administer Over the Counter Medications

Date: _____ Student Name: _____

Grade & Crew Leader: _____

Over the counter medications, approved by School Physician - Please circle those your student is allowed to take:

Acetaminophen/Tylenol	Dosage
Ibuprofen	Dosage
Benadryl	Dosage

Parent/Guardian: Name (printed) _____

Signature: _____