Waolani Judd Nazarene School

Permission to Administer Over-the-Counter Medication (ELEMENTARY/MIDDLE SCHOOL ONLY)

Student Name: _____ Grade:_____

Name of Medication: _____

Must be Refrigerated?: ☐ Yes ☐ No

Amount	Time of Day	Number of Days

I hereby authorize _____ to administer the above medication to my child.

Teacher/Staff Member

_____

Parent/Guardian Name

_____ _____

Parent/Guardian Signature Date