SPRING CREEK UMC

OTC Administration

Name: _____ Age: _____

Allergies: _____

I hereby authorize the staff of Spring Creek UMC to administer the following over-the-counter medication to my child, as needed.

_____ Acetaminophen _____ Calamine Lotion _____ Antihistamine

_____ Ibuprofen _____ Cough Syrup _____ Throat Lozenges

_____ Other _____

_____ _____

Parent Signature Date

Date:	Time	Medication Given:	Amount:	Reason	Student Initial:	Adult Initial: