HILLCREST ACADEMY
ACADEMICS that INSPIRE. FAITH that LEADS.

Medication Use

Non-Prescription Medication

The following information is to be completed by the parent for non-prescription medication and will be kept in school files.

_____
Student Name

My child has permission to receive over-the-counter medication upon request as needed.

_____ Ibuprofen – 200 mg tablet

_____ Dosage

_____ My child DOES NOT have permission to receive over-the-counter medication.

_____ _____
Parent or Guardian Signature Date

_____
Parent Phone Number

_____ _____
Physician's Name Physician's Phone Number

Prescription Medication

The following information is to be completed by the parent for prescription medication and will be kept in school files.

Student Name _____

Medication _____

Amount of dose _____ Time _____ Prescription # _____

_____ _____
Parent or Guardian Signature Date