SAN FERNANDO VALLEY ACADEMY
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OVER-THE-COUNTER MEDICINE LOG

2024-2025 SCHOOL YEAR

Student Name _____ Grade _____

Pediatrician _____ Phone (____) _____ - _____

Allergies _____

No medicine will be administered at San Fernando Valley Academy that is not in its original container and without this completed form. The bottle/package must be clearly marked with the name of the child, dosage and time(s) to be administered. It is the student's responsibility to ask the office staff for any medicine that needs to be taken home. Please send any over-the-counter medication that your student may need on a regular basis. The school office has a supply of the medications listed below. I release San Fernando Valley Academy and its personnel from any liabilities which might arise from the administration of the medication(s) I authorize below. A separate form is available for prescription medicine.

Medication my child is authorized to receive:

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil, Motrin)
- ☐ Antacid (Mylanta, Tums)
- ☐ Cough Medicine/Cough Drops
- ☐ Anti-Histamine
- ☐ Decongestant

☐ No medications are to be given.

DATE	TIME	MEDICATIONS	DOSAGE	INITIALS

Parent's Signature: _____ Date: ____ / ____ / 2024