



Participant/Student Name: _____

Parent/Guardian Names: _____

Parent/Guardian Phone Numbers (provide 2): _____

Oak Meadow School 2 Old Pickard Lane, Littleton, MA 01460 (P) 978-486-9874 (F) 978-486-3269

Oak Meadow will provide both tylenol and motrin/ibuprofen tablets. Please check off one of the following: I give my child permission to receive **TYLENOL/ACETAMINOPHEN**: _____ **MOTRIN/IBUPROFEN**: _____ **EITHER/BOTH Tylenol/Motrin**: _____ **NONE**: _____

MEDICATION ADMINISTRATION FORM

Please complete this form for both over the counter and prescription medications. Complete one row for each medication.
 Send medication in either the original over the counter packaging, or prescription labeled container that includes the student's name and instructions for administration. Please provide the appropriate amount for the duration of the participants' stay.

Medication Name (Dose)	Time of Administration	M	T	W	Th	F	S	S
	Breakfast Lunch Dinner Bedtime As Needed Other _____							
	Breakfast Lunch Dinner Bedtime As Needed Other _____							
	Breakfast Lunch Dinner Bedtime As Needed Other _____							