Request for Administering Over-The-Counter Medications by School Personnel

Student's Name:_________________________________Date of Birth:____________

Known Diagnosed Allergies:____

Current Medications:____

Significant Medical History (Seizures, Heart Problem, Diabetes, etc.):

____

____

NAME OF OTC Medication to be given: _________________________________

- Medication must be in the original unopened container labeled with the student name.
- Labels on over-the-counter medications must designate contents as MEDICATION.

Reason for Giving:____

Dosage:_________________________

****Dosage must be within the recommended amount as stated on label.

Time to be given: _______________ Start Date:___________ Stop Date: _______

****Medications are given during school hours only.

A physician written request is required if medication is to be given more than five (5) consecutive school days.

Home Phone_________________ _________________________________
Parent's Signature

Work Phone _________________ _________________________________
Date

NOTE: PLEASE INDICATE BELOW YOUR PREFERENCE REGARDING ANY UN-USED PORTION OF YOUR CHILD'S MEDICATION.

_______Parent will pick up medication.
_______Send medication home with student.

Date Medication Received_______ Date sent home or picked up by parent: _______________