Parent Request to Administer Over-the-Counter Medication

Please complete this form and return it to the school health office along with the medication you wish to be administered to your student while at school.

Student Name: _____

Grade Level: _____ Homeroom Teacher: _____

Date: _____

Name of Medication to be Administered: _____

Dosage (Amount) to be Administered: _____

Time to Be Given: _____

I request that the medication listed above be administered to my student by the school nurse or designated staff member.

Parent Signature: _____