PERMISSION FORM FOR OVER-THE-COUNTER MEDICATION

Student Name: _____

School Year: 20_____/_____ Date Form Received by School Office: _____

Grade: _____ Teacher/Classroom: _____

To Be Completed by Parent/Guardian:

Name of medication: _____

Reason for use: _____

Form of medication/treatment:
_____Tablet/Capsule _____Liquid Other:_____

Dose and time(s) to be given at school: _____

Start: _____Date form received at school Other start date: _____
Stop: _____End of school year Other stop date: _____

_____CHECK IF THIS DRUG IS ONLY FOR EPISODIC USE

Restrictions and/or Important Side Effects:
_____None anticipated
_____Yes, please describe:_____

Special storage needed: _____No _____Refrigerate Other:_____

Please indicate if you have provided additional information: _____No _____On back _____Attachment

To Be Completed by Parent/Guardian:

I request that (Student) _____ receive the above medication at school according to school policy.

Date:_____ **Signature:** _____ **Relationship:** _____

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