EASTON VALLEY
COMMUNITY SCHOOLS
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PARENT REQUEST FOR THE ADMINISTRATION OF OVER THE COUNTER MEDICATION

STUDENT'S NAME_____**DATE**_____**GRADE**_____
MEDICATION_____**DOSAGE**_____**TIME**_____
DATE TO BEGIN_____**DATE TO END**_____
REASON FOR MEDICATION_____
ANY SPECIAL INSTRUCTIONS_____

MEDICATION MUST BE IN THE ORIGINAL LABELED CONTAINER.

The student has experienced **no** previous side effects from the above medication.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same similar circumstances.

I agree to provide safe delivery of medication to and from school and pick up remaining medication.

PARENT/GUARDIAN SIGNATURE_____
DATE_____**PHONE NUMBER**_____
ALTERNATE PHONE NUMBER_____