# Request to Administer Medication

## OVER-THE-COUNTER

**Complete one form for each medication.**

Student's First Name_____ Last Name_____

Date of Birth_____ Sex: ☐ M ☐ F

School _____ Grade _____

Parent/Guardian's First Name _____

Parent/Guardian's Last Name _____

Name of Medication/Treatment: _____

Reason for Medication/Treatment: _____

_____

Frequency to be administered:_____

Dose: _____

Possible Adverse Reactions/Side Effects: _____

_____

***I, the parent or legal guardian of the above named student, shall notify in writing the school principal if there is a cancellation of this medication. I understand that I must submit a new request if this medication changes. I further give permission for designated school personnel to administer the above medication to my child. This form shall also permit designated school personnel to share and request relevant health information regarding the administration of this medication. Medications are NOT given by licensed medical personnel.***

Parent/Legal Guardian Signature _____ Date _____