



PARENT REQUEST FOR OVER-THE-COUNTER

(non-prescription) MEDICATION

Grade 1 - 8 Students

Medication must be an age appropriate product in the original manufacturer's package, not expired and labeled with the student's first and last name.

Medication medically necessary during school hours or on an overnight field trip will be accepted. Only the nurse at school or trained St. John's Episcopal staff may administer medication to students. Students may not self-carry medication.

NAME OF STUDENT: _____ **DOB:** _____

TEACHER: _____ **GRADE:** _____

NAME OF MEDICATION: _____

DOSAGE (amount): _____ **ROUTE:** _____

TIME TO BE GIVEN: _____ **OR AS NEEDED:** _____

REASON/SYMTOM/HEALTH PROBLEM: _____

Parent Name: _____ **Daytime Phone:** _____

Parent Signature: _____ **Date:** _____

Physician's Name: _____ **Physician's Phone:** _____

Nurse's Signature: _____ **Date:** _____

This authorization is good for one school year