REQUEST FOR ADMINISTRATION OF **NON-PRESCRIPTION** MEDICATION DURING SCHOOL HOURS BY SCHOOL PERSONNEL

Name of Student____D.O.B.__________________

I hereby request and give permission to the school nurse or other authorized personnel to administer the following medication to my child:

Name of Medication____

Dosage Strength____

Directions____

Remarks/Comments____

MEDICATION MUST BE BROUGHT TO THE SCHOOL IN THE UNOPENED ORIGINAL CONTAINER AS DISPENSED BY THE DRUG STORE OR PHARMACY

If any revisions in the above request occur, a written revised statement must be submitted to the school.

Parent/Guardian Signature____ Date___________