

SELF-MEDICATION REQUEST FORM (Over-the-Counter Medication)

To be completed by the Parent/Guardian

Student Name _____ School _____

School Year _____ Grade/Teacher _____ Date of Birth _____

Address: _____

I request that my child be allowed to possess and self administer his/her over-the-counter medication while at school and for school related activities. I realize there are protocols and safety issues at school that the school nurse will review with my child. These include:

- 1) Over-the-counter medications must be in their original container
- 2) There is to be no sharing of over-the-counter medications.

My child's physician or other prescribing healthcare provider is aware that this medication may be necessary for my child to take during the school day. My child has taken this medication before without side effects. This form must be completed yearly.

My child has the following health condition(s): _____

In the event of an adverse reaction to an over-the counter medicine, please do the following:

_____/_____/_____
 Parent/Guardian Signature Date Phone number (home/work/cell)

School use: Date received: _____ Initials: _____

School Nurse notified by: (place date in one box) E-mail _____ Phone _____ Mailbox _____ In person _____

School Nurse Signature: _____ Date _____