WOOSTER CITY SCHOOL DISTRICT *Form 5330 – B*

OVER-THE-COUNTER MEDICATION REQUEST FORM

To be completed by the Parent/Guardian

Student Name______________________________ School ______________

School Year__________ Grade/Teacher______________ Date of Birth__________

My child has the following health condition (please describe): ______________________

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In my absence, while my child is attending school, I request that the school nurse, the principal or the principal's designee administer the following over-the-counter medication to my child using the following directions.

Name of Medication	Amount of Medication	Time to be Administered	Form of Medication
_______Ex. Tylenol	160 mg (one jr strength)	as needed/every 4 hrs. for pain	pill/ by mouth

1.____

2.____

Date Administration is to begin________________ ending date______________

My Child's physician or other prescribing healthcare provider, is aware that this medication is necessary for my child to take during the school day. My child has taken this medication before without side effects. I further understand that it is my responsibility to pick up any leftover medication at the end of the administration dates. I realize that this form will not be used next year or after the above dates.

______________________ __________ __________/__________/__________

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__________