WOOSTER CITY SCHOOL DISTRICT

Form 5330 - F

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_____

8/07