



Parent/Guardian Request for Administration of Over-the Counter Medication During School Hours

Student Name & Grade _____
Medication to be Given _____
*Medication Dosage _____
Reason for Medication _____
Time to be Given _____

(Parent/Guardian Signature) (Date)

*Dosage may not exceed manufacture’s recommended dosage. The School Nurse reserves the right to withhold over-the-counter medication based on the student’s condition or potential for excessive medication ingestion.

M3/RP14
(Revised 5/05)



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