



**REQUEST for OVER the COUNTER MEDICATION
/SHORT TERM MEDICINE at SCHOOL**



Date: _____

I _____ hereby give _____ permission
(Parent/Guardian) (School)
to administer medication to my child _____
(Child's Name)

Name of Medication: _____

Dosage to be given: _____

Time to be given: _____

Homeroom Teacher: _____

Grade: _____

Reason Medication is needed at school: _____

I understand the school can only administer medication for up to **10 consecutive days**. After that time, I will be required to have a doctor fill out a request for administration of medication at school.

Parent's Signature: _____

Mother's Name and Work Number: _____

Father's Name and Work Number: _____

Home Phone Number: _____

Emergency Person: _____

Phone Number: _____

Any questions, please contact Health Related Services Department at 929-7767.

Any over-the-counter medication sent to the school must be in its original bottle, unopened and sealed. This is for your child's protection as well as for ours. Thank you for your help.

Office Use Only:

Medication Received By:

(478) 929-7767



FAX (478) 929-6231