

## Request for Over-the-Counter Medication /Short Term Medication at School

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	(St	tudent Name)	(Teacher/Grade)	(Birthdate)	(Student ID#)
	chool System to a	assist students in taking	eturned to the school in og their medication during	school hours.	ston County
	<ul> <li>All over-the with age ap</li> </ul>	e-counter medication br	ctly to the office upon arri rought to the school must NED BOTTLES OF MEDICATI	be in its origina	
Medication					
Dose					
Time					
Reason for Medication					
			OR		
	Inhaler	Directions:			
	Diastat	Directions:			
	Glucagon	Directions:			
	Epinephrine Auto Injector	Allergy Requiring Medicati	on:		
w			medication, please ir erson during school a		
di th th	s parent/guardiar rected below. I use policy and processed e-counter medical complete a REQUE	understand that school cedures of the school sy ation for up to <b>10 DOS</b>	tudent, I request the school personnel will administer stem. I understand the set of the	the medication school can only a be required to	in accordance with administer over- have a doctor
(Signature of Parent/Guardian)					(Date)
_	(Printed Na	me of Parent/Guardian)	(Cell Phon	/	Work Phone)



Number/Amount of Medication Received: \_\_\_\_\_

Medication Received by: \_\_

\_\_\_\_\_ Expiration Date: \_\_\_\_\_

Date: \_\_\_\_\_