Frederick County Public Schools

Student Support Services

Parent/Guardian Request for Giving Medication at School
Over the Counter/Short Term Medication Form

Student's Name: ____________________________ **School: ____________________________________**

I request for the nurse or designee to give my child the following medication:

Medication: ____

(medication name as it appears on the container)

Medication to be given for the following condition(s): ____

Dose: ____

(if desire nurse to follow directions on medication container—please write *per medication container* in space above)

please be aware that unless you have a doctor's order, we cannot exceed the dose listed on the medication container

Time(s) to be given: ___________________________________ _______________

(if desire medication to be given only as needed—write *as needed* in space above)

Do you desire for the medication to stay in the clinic and be used for the remainder of the school year? *(please circle one)* Yes / No

If no, please state when you would like the medication sent home:______________________________________

Medication must be in the original unexpired container/bottle, with the original label affixed. If it is a prescription medication, it must be in the original container with the pharmacy label on it containing the student's name and medication dosing information.

Signature of parent/guardian:____Date:__________________

Relationship to student:____

Home Phone #:______________________________Work/Cell Phone #:_________________________________