OVER THE COUNTER MEDICATION
PERMISSION FORM

Student: _____ DOB: _____

Name of Medication: _____

Specific time(s) and dose(s) to be given at school: _____

_____

Length of time to be given: _____

Reason(s) for medication to be given: _____

_____

I request that the school nurse or principal designee(s) administer the above medication to my child during school hours and at the times indicated. I agree to furnish said medication in the **ORIGINAL** container with the label intact. I understand and accept that the Washington County School Board, its employees, agents or designees are not responsible for any effects of the medication administered.

**Any non-prescription medication that is requested excessively by the student will be brought to the attention of the parent and consultation with physician may be required to continue medication.*

***Parents are required to deliver medications to the school's office. Students are prohibited from carrying medications on the school bus unless special permission has been obtained from the principal.*

_____ _____

Date Signature of Parent/Legal Custodian

REV/08