Over-the-Counter Medication Form

Date _____

I am requesting and hereby give permission to school personnel to give the following medication during school hours to my child named below in order to maintain my child's physical health and support school performance. To my knowledge, my child has no allergy to this medication.

_____ Child's Name

_____ Date of Birth

_____ Parent Signature

_____ Telephone Number

_____ Date

_____ Name of Medication

_____ Dosage

_____ Frequency (how often to be given)

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS:
The medication listed above must be supplied by the parent/guardian and must be in the original manufacturer's container with an original label containing dosage instructions. *Please do not send OTC medications in baggies or other containers.*

Please return this form to the school nurse, nurse@stmarkhouston.org or fax to 713 468 6735.