

OVER THE COUNTER PERMISSION FORM

OVER-THE-COUNTER MEDICATION REQUEST

Student: _____

DOB: _____

Medication: _____

Dosage: _____

Frequency: _____

Duration: _____

Reason for medication: _____

I, _____, the parent/legal custodian of _____, request that the school nurse or principal's designees administer this medication to the above-named student during school hours and at the times indicated. I agree to furnish said medication in an unopened, **ORIGINAL** container supplied by the pharmacy with the label intact. I understand and accept that the Henrico County School Board, its employees, agents or designees are not responsible for any effects of the medication administered.

Any nonprescription medication that is to be given for more than three (3) consecutive school days must be authorized in writing by a physician. If medication dosage exceeds recommended dosage/age a physician's note is requested.

Date _____

Signature of Parent/Legal Custodian _____

Home Tel. No. _____

Work Tel. No. _____

School Name: _____

Phone # _____ Fax # _____

NOTE: PLEASE RETURN THIS FORM WITH MEDICATION TO YOUR CHILD'S SCHOOL.

PHYSICIAN TO COMPLETE IF: (please circle appropriate statement)

1. MEDICATION IS TO BE GIVEN FOR MORE THAN THREE (3) CONSECUTIVE SCHOOL DAYS
OR
2. DOSAGE REQUESTED BY PARENT EXCEEDS RECOMMENDED DOSAGE / AGE ON LABEL

Signature of Physician

Date

Printed signature of Physician

Telephone # _____

Date Received	Medication Name	Quantity Received	Received from	Exp. Date	Nurse initials

Entered & scanned into Welligent _____ (initials)

Notes:

Nurse signature _____ Date _____