**OVER-THE-COUNTER MEDICATION REQUEST FORM**

---

**Physician's note is requested.**

Physician. If medication dosage exceeds recommended dosage, a prescription for medication must be authorized by writing in the quantity prescribed by a physician. Any nonprescription medication that is to be given for more than three days must be authorized by a physician. A written order from a physician is required. The parent/legal custodian shall provide the appropriate medication in an unopened original container. The pharmacist is responsible for administering this medication to the above-named student.

---

**Reason for Medication:**

**Duration:**

**Frequency:**

**Dosage:**

**Medication:**

**DOB:**

---

**NOTE:** Please return this form with medication to your child's school.

---

**Telephone:**

**Name:**

**Received Date:**

**Exp. Date:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**From:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**

---

**Printed Signature of Physician:**

**Date:**

**Received:**

**Date:**

**Name:**

**Quantity:**