

**Self-Administration of Over-the-Counter Medication by Students
In Grades Six and Above
Principal Notification Letter**

*(This form applies only to medications that can be bought without a Health Care Provider's prescription. **This form is not used for prescription medications.**)*

Date: _____

Dear Principal: _____ School: _____

I am choosing to allow my child, _____ to self-administer the following **over-the-counter medication**:

Name of medication: _____

Dosage of tablets: _____

Number of tablets to be taken: _____

Times per day: _____

Time last dose taken: _____

Reason medication is being taken: _____

I understand that you request that my child bring this medication to school in its original container with **only** one (1) day's dose. I also understand, that by signing this letter, I am releasing Franklin County Schools of responsibility for supervising my child's self-administration of this medication.

Parent/Guardian Signature

Date

I understand that I will carry the above medication in the original container with only one day's dose, will take it as instructed above and will not share the medication with anyone.

Student's Signature

Date

Reviewed by School Nurse: _____ **Date:** _____

cc: Student