Cohasset Public Schools
OVER-THE-COUNTER MEDICATION FORM

Start Date: _____ End Date_____

Student's Name: _____

Medication: _____

Dosage: _____

Frequency/route:_____

Allergies: _____

***ALL MEDICATION must be labeled with the student's name.**

***OVER THE COUNTER MEDICATION must be in the original Manufacturer's container and be marked with the student's name.**

Parent Name: _____

Parent Signature: _____

Cohasset Middle High School`	**Deer Hill School**	**Joseph Osgood School**
143 Pond Street	208 Sohier Street	210 Sohier Street
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