Great Falls Public Schools

PARENT REQUEST FOR ADMINISTERING
OVER THE COUNTER MEDICATION

We are aware that at times it may be necessary for a student to take over counter medications while at school. It is preferred, if at all possible, that medication be administered at home. In the event it is absolutely necessary that the student take medication during the school day, this form must be completed and signed by the parent or guardian before the student can begin taking the medication at school.

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Medication Directions: Please describe the medicine, dosage, at what time it should be administered, and the purpose of the medication.

Patient's Name: _____ **DOB**: _____

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

_____

_____

Parent Information/Permission: The staff responsible for _____

has my permission to assist with self-administration of the medication.

_____ _____

Parent/Guardian Signature **Date**

_____

Parent: Please list below any medications not listed above that are taken at home whether they are prescription or over the counter medications. This information is required in the event of an emergency medical situation while at school.
Before emergency medical services can be performed it is important to know what medication the child may have taken that day.

MEDICATION	DOSE	TIME

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