

**Request for Over-the-Counter Medication
/Short Term Medication at School**



This form must be completed in full and returned to the school in order for the Houston County School System to assist students in taking their medication during school hours.

- All medication must be taken directly to the office by the parent.
- All over-the-counter medication brought to the school must be in its original bottle, unopened with age appropriate dosing. **OPENED BOTTLES OF MEDICATION WILL NOT BE ACCEPTED.**
- One medication listed per form.

STATEMENT OF PARENT/GUARDIAN

As parent/guardian of the below named student, I request the school system to give medication as directed below. I understand that school personnel will administer the medication in accordance with the policy and procedures of the school system. I understand the school can only administer over-the-counter medication for up to **10 DOSES**. After that time, I will be required to have a doctor complete a *REQUEST FOR ASSISTIVE ADMINISTRATION OF MEDICATION* (HRS 29) form in order for my child to continue to receive the medication at school.

(Signature of Parent/Guardian) (Date)

(Printed Name of Parent/Guardian) (Cell Phone) / (Work Phone)

(Student Name) (Birthdate) (Student ID#)

| | |
|------------------------------|--|
| Medication | |
| Dose | |
| Time | |
| Reason for Medication | |

OR

IF YOUR CHILD REQUIRES AN EMERGENCY MEDICATION, PLEASE INDICATE BELOW:

| | |
|----------------------------------|--------------------------------------|
| Inhaler | Directions: |
| Diastat | Directions: |
| Glucagon | Directions: |
| Epinephrine Auto Injector | Allergy Requiring Medication: |

OFFICE USE ONLY:

Medication Received by: _____ Date: _____

Number/Amount of Medication Received: _____ Expiration Date: _____