TRENTON ISD
OVER-THE-COUNTER MEDICATION FORM

TRENTON ISD DOES NOT PROVIDE ANY OVER-THE-COUNTER MEDICATIONS.

STUDENTS NAME _____DOB_____

GRADE _____

MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER, WITH STUDENTS NAME, AND WITHIN THE EXPIRATION DATE. ONLY MEDICATIONS THAT MUST BE GIVEN DURING SCHOOL HOURS WILL BE GIVEN.

MEDICATION (NAME) _____

DOSAGE (AMOUNT TO BE GIVEN) _____

HOW OFTEN GIVEN _____

WHY GIVEN _____

HOW LONG MEDICATION IS TO BE GIVEN _____

PARENT OR GUARDIAN MUST BRING MEDICATIONS TO THE SCHOOL. DO NOT SEND BY STUDENT.

NO MEDICATION WILL BE GIVEN UNTIL THIS RECORD IS COMPLETED. **ONLY MEDICATION PROVIDED BY AND REQUESTED BY A PARENT/GUARDIAN WILL BE DISPENSED.**
I GIVE MY PERMISSION FOR THIS MEDICATION/TREATMENT TO BE GIVEN TO MY CHILD AS DIRECTED ABOVE, BY AUTHORIZED SCHOOL PERSONNEL. THE MEDICATION IS IN THE ORIGINAL CONTAINER LABELED FOR MY CHILD.
BY SIGNING BELOW I RELEASE THE SCHOOL AND ITS STAFF FROM ALL LIABILITY FOR REACTIONS WHICH MY CHILD MAY SUFFER FROM THIS MEDICATION.

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

PHONE NUMBER _____