



Over the Counter Medication

Name of Student _____ Grade _____

Medication _____ Date of Order _____

Diagnosis _____ Dosage _____

Route _____ Time _____ Specific Duration of Order _____

Medication _____ Date of Order _____

Diagnosis _____ Dosage _____

Route _____ Time _____ Specific Duration of Order _____

Medication _____ Date of Order _____

Diagnosis _____ Dosage _____

Route _____ Time _____ Specific Duration of Order _____

I request that the school administer the above over the counter medications.

Parent/Guardian's Printed Name _____

Parent/Guardian's Signature _____

Date _____