



Over the Counter Medication 2008 - 2009

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 Signature _____

Parent/Guardian's Name (printed) _____

Date _____