



Frederick County Public Schools

... to ensure all students an excellent education

Student Support Services

Parent/Guardian Request for Giving Medication at School Over the Counter/Short Term Medication Form

Student's Name: _____ School: _____

I request for the nurse or designee to give my child the following medication:

Medication: _____
(medication name as it appears on the container)

Medication to be given for the following condition(s): _____

Dose: _____
(if desire nurse to follow directions on medication container—please write *per medication container* in space above)

****please be aware that unless you have a doctor's order, we cannot exceed the dose listed on the medication container****

Time(s) to be given: _____
(if desire medication to be given only as needed—write *as needed* in space above)

Do you desire for the medication to stay in the clinic and be used for the remainder of the school year?
(please circle one) Yes / No

If no, please state when you would like the medication sent home: _____

***Medication must be in the original unexpired container/bottle, with the original label affixed.
If it is a prescription medication, it must be in the original container with the pharmacy label on it
containing the student's name and medication dosing information.***

Signature of parent/guardian: _____ Date: _____

Relationship to student: _____

Home Phone #: _____ Work/Cell Phone #: _____