MEDICATION PERMISSION FORM

OVER-THE-COUNTER MEDICATION REQUEST

Student___________________________________

DOB:_____________________________________

Medication ____

Dosage ____________________________________

Frequency__________________________________

Duration ___________________________________

Reason for medication ______________________

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I, ______________________________________, the parent/legal custodian of ______________________, request that the clinic attendant/school nurse or principal's designees administer this medication to the above named student during school hours and at the times indicated. I agree to furnish said medication in an unopened, **ORIGINAL** container supplied by the pharmacy with the label intact. I understand and accept that the Henrico County School Board, its employees, agents or designees are not responsible for any effects of the medication administered.

Any nonprescription medication that is to be given for more than three (3) consecutive school days must be authorized in writing by a physician. If medication dosage exceeds recommended dosage/age a physician's note is requested.

Date ___________ ___________________________________

Signature of Parent/Legal Custodian

Home Tel. No. _____________________

Work Tel. No. _____________________

NOTE: PLEASE RETURN THIS FORM WITH MEDICATION OR FAX IT BACK TO YOUR CHILD'S SCHOOL, ATTN: CLINIC ATTENDANT SCHOOL NURSE.

PHYSICIAN TO COMPLETE IF: (please circle appropriate statement)

1. **MEDICATION IS TO BE GIVEN FOR MORE THAN THREE (3) CONSECUTIVE SCHOOL DAYS**

OR

2. **DOSAGE REQUESTED BY PARENT EXCEEDS RECOMMENDED DOSAGE / AGE ON LABEL**

______________________________ ____________

Signature of Physician Date

Telephone No. ________________

Medication Received	Name of Medication	Received From