

WASHINGTON COUNTY SCHOOLS

OVER-THE-COUNTER MEDICATION
PERMISSION FORM

(For medicines requested to be given for more than three (3) consecutive days
or periodically throughout the school year)

Student: _____ DOB: _____

Name of Medication: _____

Specific time(s) and dose(s) to be given at school: _____

Length of time to be given: _____

Reason(s) for medication to be given: _____

I, _____, the parent/legal custodian of _____, request that the clinic attendant/school nurse or principal designees administer the above medication to my child during school hours and at the times indicated. I agree to furnish said medication in the **ORIGINAL** container with the label intact. I understand and accept that the Washington County School Board, its employees, agents or designees are not responsible for any effects of the medication administered. Any non-prescription medication that is requested excessively by the student will be brought to the attention of the parent.

Date _____

Signature of Parent/Legal Custodian

Note: Parents are *required* to deliver medications to the school's office. Students are prohibited from carrying medications on the school bus unless special permission has been obtained from the principal.