COLUMBUS CLASSICAL ACADEMY

Request form for the administration ***OTC/Non-Prescription*** *medication at school*

(One medication per form)

I hereby request and give my permission to the Head of School or his designee (school nurse or other responsible person) to administer the following medication to my child.

To be filled out by the Parent/ Guardian.

Student: _____ Year: _____ Grade: _____

Medication: _____

Specific dosage: _____

Reason for administration/ diagnosis: _____

_____

Dates to be given: _____ to _____

Time(s) of the Day: _____am/pm

_____am/pm

_____am/pm

_____ As needed

Note to Parent/ Guardian: Your child's medication must be supplied in the original manufacturer's packaging and labeled with their name.

Parent/ Guardian signature: _____ Date: _____

*If the over the counter medication dose is out of range for your child's age or weight please have their physician fill out the bottom portion of this form.

Reason for increased dose: _____

Physician name printed: _____

Physician signature: _____

Physician contact information: _____