WOOSTER CITY SCHOOL DISTRICT

SELF-MEDICATION REQUEST FORM (Over-the-Counter Medication)

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To be completed by the Parent/Guardian

Student Name_________________________ School _______________________

School Year____________________ Grade/Teacher_____________________ Date of Birth_____________________

Address:________________________________________________________________________

I request that my child be allowed to possess and self administer his/her over-the-counter medication while at school and for school related activities. I realize there are protocols and safety issues at school that the school nurse will review with my child. These include:

1) Over-the-counter medications must be in their original container
2) There is to be no sharing of over-the-counter medications.

My child’s physician or other prescribing healthcare provider is aware that this medication may be necessary for my child to take during the school day. My child has taken this medication before without side effects. This form must be completed yearly.

My child has the following health condition(s): ____________________________________________

____________________________________________________________________________________

In the event of an adverse reaction to an over-the-counter medicine, please do the following:

____________________________________________________________________________________

____________________________________________________________________________________

Parent/Guardian Signature ___________________________ Date / __________ / __________ Phone number (home/work/cell) _____________________________

School use: Date received: ________________________ Initials: __________________________

School Nurse notified by: (place date in one box) E-mail ______ Phone ______ Mailbox ______ In person ______

School Nurse Signature: __________________________________________ Date__________

8/07