



Request for Medication Administration
OVER THE COUNTER
(To be completed by parent or legal guardian)

Student Information (please fill out one form per student):

Name Birth Date
Grade Teacher Rm #

Emergency contact information:

Parent/Legal Guardian Name Relationship
Physical Address
Home Phone Cell Phone
Work Phone

Medication Information (please fill out one form per medication):

Medication Name
Dosage Instructions as indicated on the product's label

Dosing Supplies
Begin Administration Terminate Administration
Medication Expiration

I request that the school administer the above medication to my child in accordance with the product's label. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medication or with any changes to the information provided on this original form. I understand that it is my responsibility to send an appropriate supply of medication to school in its original container. Medication provided to the school in any container other than the original will not be accepted. I understand that those employees administering medication are non-medical personnel and that this agreement exempts and relieves all FBCS employees and its officers from liability.

X
Signature of Parent or Legal Guardian Date

For Office Use Only:

Medication Stored: In Office In Classroom # Lockbox #
Expired Medication Notification: 1st Notification Date: Initials: Phone Email In Person
Medication disposed of by FBCS on Date: Medication picked up by Date: