

**CARDINAL PACELLI SCHOOL**

**PARENT'S REQUEST FOR THE ADMINISTRATION OF OVER THE COUNTER  
MEDICATION BY SCHOOL PERSONNEL\***

I hereby request and give my permission to the principal and his/her delegate (school nurse or other responsible person) to administer the following over the counter medication to my child:

Name of student \_\_\_\_\_ Grade \_\_\_\_\_

Address of child \_\_\_\_\_

Condition for which medication is administered \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Route \_\_\_\_\_ at the following time(s) \_\_\_\_\_

Start date \_\_\_\_\_ End date \_\_\_\_\_

Drug in original container? \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature of Parent or

Guardian \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_

\*Parent will be called prior to over the counter medication being administered to student.