

**REQUEST FOR NON-PRESCRIPTION MEDICATION ADMINISTRATION AT SCHOOL**

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**I request that my child receive the following over-the-counter medication in the University School of the Lowcountry office from an administrator (or a person designated by the head of school). I understand that the medication is to be furnished by me in the original container, labeled with the name of the student, the name of the medication, the dosage to be given, and time(s) of day to be taken.**

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time of day to be given: \_\_\_\_\_ Reason: \_\_\_\_\_

**I will not hold University School of the Lowcountry or the head of school (or person designated by the head of school) liable for any adverse reaction experienced by the student.**

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_