Holston High School Band

OVER-THE-COUNTER MEDICATION PERMISSION FORM

Student Information

Student Name: _____ **DOB:** _____ **Grade:** _____

Medication Information

Name of Medication: _____

Specific Time(s) to be Given: _____

Dose(s) to be Given: _____

Length of Time to be Given: _____

Reason(s) for Medication: _____

I request that the school nurse or principal designee(s) administer the above medication to my child during school hours and at the times indicated. I agree to furnish said medication in the **ORIGINAL** container with the label intact. I understand and accept that the Washington County School Board, its employees, agents or designees are not responsible for any effects of the medication administered.

** any non-prescription medication that is requested excessively by the student will be brought to the attention of the parent and consultation with a physician may be required to continue medication*

*** parents are **required** to deliver medications to the school office. Students are prohibited from carrying medications on the school bus unless special permission has been obtained from the school principal*

_____ _____

Signature of Parent/Legal Guardian **Date**

rev. 3/20/17

** forms are shredded and discarded after the end of each school year **