L'Anse Area Schools
Over The Counter Medication

Student: _____ Date of Birth: _____
Last name First MI
Grade: _____ Teacher: _____

Section I: To be completed by parent/guardian.

1. Name of medication: _____
2. Reason for medication: (optional) _____
3. Form of medication/treatment: ___ Tablet/capsule ___ Liquid ___ Other: _____
4. Instructions (Schedule and dose to be given while students is in school): _____
   _____
   Start: ___ date form received OR Other dates: _____
   Stop: ___ end of school year **OR** Other date/duration: _____

   ___ For episodic/ emergency use only.
5. Restrictions and/or important side effects: ____ None anticipated _____ Yes, please specify/describe: _____
   _____
6. Special storage requirements: ___ Refrigerate ____ None ___ Other _____
7. This student is both capable and responsible for self-administering this medication:
   ___ No ___ Yes-Supervised ___ Yes-Unsupervised
8. This student may carry this medication: ___ Yes
9. Please indicate if you have provided additional information: ___ As an attachment

Section II: To be completed by the parent/guardian and returned to school:

I request that (name of student) _____ receive the above medication at school according to standard school policy and the physician orders.

I request that (name of student) _____ be allowed to self-administer the above medication at school according to the school policy.

Signature: _____ Relationship: _____ Date: _____

Section III: To be completed by the student.

I understand that I will follow the medication policy guidelines. If I am permitted to carry and self-administer my medication, I will not give my medication to another student.

Signature: _____ Date: _____