Houston County Board of Education

Health Related Services

Request for Over-the-Counter Medication /Short Term Medication at School

(Student Name)	(Teacher/Grade)	(Birthdate)	(Student ID#)

This form must be completed in full and returned to the school in order for the Houston County School System to assist students in taking their medication during school hours.

- All medication must be taken directly to the office upon arrive to school.
- All over-the-counter medication brought to the school must be in its original bottle, unopened with age appropriate dosing. ***OPENED BOTTLES OF MEDICATION WILL NOT BE ACCEPTED.***
- One medication listed per form.

Medication	
Dose	
Time	
Reason for Medication	

OR

☐	**Inhaler**	**Directions:**
☐	**Diastat**	**Directions:**
☐	**Glucagon**	**Directions:**
☐	**Epinephrine Auto Injector**	**Allergy Requiring Medication:**

If your child requires an emergency medication, please indicate below if your student will have this medication on their person during school and is competent in the use of the medication.

YES ☐ **No** ☐

STATEMENT OF PARENT/GUARDIAN

As parent/guardian of the above named student, I request the school system to give medication as directed below. I understand that school personnel will administer the medication in accordance with the policy and procedures of the school system. I understand the school can only administer over-the-counter medication for up to ***10 DOSES***. After that time, I will be required to have a doctor complete a *REQUEST FOR ASSISTIVE ADMINISTRATION OF MEDICATION* (HRS 29) form in order for my child to continue to receive the medication at school.

_____ _____

(**Signature of Parent/Guardian**) (**Date**)

_____ _____ / _____

(**Printed Name of Parent/Guardian**) (**Cell Phone**) (**Work Phone**)

OFFICE USE ONLY:

Medication Received by: _____ Date: _____

Number/Amount of Medication Received: _____ Expiration Date: _____

(478) 988-6200, Ext. 27767 *Fax: (478) 328-1407*

Houston County Board of Education
High-Achieving Students