PARENT REQUEST for the ADMINISTRATION of

OVER-THE-COUNTER MEDICATIONS

STUDENT_____GRADE_____

NAME OF
MEDICATION and
DOSAGE_____

Times of day to be
Administered_____

Number of Times/Intervals
Medication to be Administered_____

Special Instructions
for Administration of
Medication_____

_____

DATE to Begin Medication_____Date to End Medication_____

Please regard my signature below as my assurance that I release South Euclid Lyndhurst Schools, PSI, and any or all of the school's and PSI officer's or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in this request. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____

Parent's Signature **Date**