

**Self-Administration of Over-the-Counter Medication by Students
In Grades Six and Above
Principal Notification Letter**

*(This Form applies only to medications that can be bought without a Health Care Provider's prescription. **This form is not used for prescription medications.**)*

Date: _____

Dear Principal: _____ School: _____

I am choosing to allow my child, _____ to self-administer the following **over-the-counter medication**:

Name of medication: _____

Dosage of tablets/amount of liquid: _____

Number of tablets/spoonfuls: _____

Times per day: _____

Time last dose taken: _____

Reason medication is being taken: _____

I understand that you request that my child bring this medication to school in its original container with **only** one (1) day's dose. I also understand, that by signing this letter, I am releasing Franklin County Schools of responsibility for supervising my child's self-administration of this medication.

Parent/Guardian Signature

Date

Student's Signature

Date

Principal's Signature

Date

cc: School Nurse
Student