



OVER-THE-COUNTER MEDICATION FORM
HARTFORD UNION HIGH SCHOOL



Date: _____

My child, _____ has my permission to take _____
at a dosage of _____ every _____
for (medical reason) _____.

I feel my child is capable of administering their own over-the-counter medication and that they understand the risks of medication and of not administering it correctly. My child also understands that these medications are for them only and they will not share them with other students. My child will keep the medication in the original container with the students name on it and keep this paper with the medication in a Ziplock bag.

Signature of Parent/Guardian: _____