REQUEST FOR NON-PRESCRIPTION MEDICATION ADMINISTRATION AT SCHOOL
2024-2025 School Year

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Name of Student: _____ Grade: _____

Date of Birth: _____ Height: _____ Weight: _____

I request that my child receive the following over-the-counter medication in the University School of the Lowcountry office from an administrator (or a person designated by the head of school). I understand that the medication is to be furnished by me in the original container, labeled with the name of the student, the name of the medication, the dosage to be given, and time(s) of day to be taken.

Medication: _____ Dosage: _____

Time of day to be given: _____Reason: _____

I will not hold University School of the Lowcountry or the head of school (or person designated by the head of school) liable for any adverse reaction experienced by the student.

Name of Physician: _____ Phone: _____

Physician's Address: _____

Signature of Physician: _____ Date: _____

Signature of Parent: _____ Date: _____