OVER THE COUNTER MEDICATION

Student Name _____ **Date of Birth** _____

Grade _____ **Teacher** _____

Medication _____

Dosage _____

Medication Begin Date _____

Medication End Date _____

I, _____**, give permission for a trained member of Bath Schools to give my child the above mentioned medication while at school.**

Parent Signature _____ **Date** _____

(For School Use)

Date	Time	Dosage	Staff Initials