# GLENVILLE-EMMONS INDEPENDENT SCHOOL # 2886

**2023-2024 SCHOOL YEAR3**

**OVER-THE-COUNTER/SHORT TERM MEDICATION REQUEST AND AUTHORIZATION**

**PLEASE TYPE OR PRINT:**

NAME:_____ DOB: _____
Last First Middle

**FOR THE PARENT**

1. Medication _____Method of Administering Medication_____

   Dosage_____ Time to be given in school _____

2. Diagnosis and medical reason for this medication:_____

   _____

3. **We understand that the Glenville-Emmons School ISD #2886 is NOT responsible if the child has a reaction from this medication.**

4. We would like this medication discontinued on (end of school year):_____
   If this should change, we will notify the school.

5. We request School personnel to give the above student medication.

6. We will provide the medication in the **original container labeled** with the child's name.

Parent's signature:_____ Date:_____

**Any medication left will be sent home at the end of the school year.**