MAGGIE L. WALKER GOVERNOR'S SCHOOL
FOR GOVERNMENT & INTERNATIONAL STUDIES
Complete Academic Year Here: ___________________

OVER-THE-COUNTER MEDICATION REQUEST

Student __________________________ DOB: _______________

I, ____, the parent/legal custodian of __________________________________, request that the school nurse, clinic attendant or principal's designees administer over the counter medications to ____________________________________ during school hours and at the times indicated.
Medication name:_____________________________________
Medication dose and frequency:______________________________
Students **MUST** have their own brands with written permission in the **ORIGINAL** container with the label intact. **No medication will be given to students under any circumstance if they do not have their own.** The MLWGSGIS Regional School Board, its employees, agents or designees are not responsible for any effects of the medication administered. Any nonprescription medication that is to be given for more than three (3) consecutive days must be authorized in writing by a physician. **Medication must be picked up by the parent at the end of the school year, or it will be discarded.**

Date _____________________ ____________________________
Signature of Parent/Legal Custodian

***Permission for Student Administration of Inhalant Medications and Authorization for Medication upon request. This form must be returned with medication(s) by the parent to Mrs. Shapiro in the Clinic, room 101.**