

**TRENTON ISD
OVER THE COUNTER MEDICATION RELEASE**

MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER, WITH STUDENTS NAME, AND EXPIRATION DATE. ONLY MEDICATIONS THAT MUST BE GIVEN DURING SCHOOL HOURS WILL BE GIVEN.

MEDICATION (NAME) _____

DOSAGE (AMOUNT TO BE GIVEN) _____

HOW OFTEN GIVEN _____

WHY GIVEN _____

STUDENTS NAME _____

GRADE _____

HOW LONG MEDICATION IS TO BE GIVEN _____

PARENT OR GUARDIAN MUST BRING MEDICATIONS TO THE SCHOOL. DO NOT SEND BY STUDENT.

NO MEDICATION WILL BE GIVEN UNTIL THIS RECORD IS COMPLETED. ONLY MEDICATION PROVIDED BY AND REQUESTED BY A PARENT/GUARDIAN WILL BE DISPENSED.

BY SIGNING BELOW= I RELEASE THE SCHOOL AND ITS STAFF FROM ALL LIABILITY FOR REACTIONS WHICH MY CHILD MAY SUFFER FROM THIS MEDICATION.

PARENT/GUARDIAN SIGNATURE

DATE

PHONE NUMBER _____