

**VICTOR SCHOOL  
OVER-THE-COUNTER MEDICATION**

**STUDENT NAME:** \_\_\_\_\_

**Medication:** \_\_\_\_\_

**Reason for Medication:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_

**Number of times Medication to be given per day:** \_\_\_\_\_

**Period of time to be given from** \_\_\_\_\_ **to** \_\_\_\_\_ .  
(Cannot exceed 45 school days)

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_