St. Thomas More School
Chapel Hill, North Carolina

Medication Request Form

❖❖ To be completed by Parent ❖❖

Student's Name ____________________________________ Class ___________

Medication ________________________________ Dosage ________________________

Check one: _______ Tablet _________ Capsule

_______ Liquid _________ Eye Drops

Dates to be given: From ______________ to ________________

Times to be given: ______ a.m. ______ p.m. _______ As needed

This form will allow the nurse to provide "over the counter" medications listed above on an occasional basis to your child. If the named medications are needed on a regular basis, please provide that "over the counter" medication, in the original container with the student's full name written on it.

I hereby give permission for my child (named above) to receive the above-mentioned medication during school hours. I understand that the school undertakes no responsibility for the effects of this medication when it has been properly administered. I hereby release St. Thomas More School and their employees and agents from any and all liability that may result from my child taking the above named medication, according to the written instructions I have given.

Parent/Guardian Signature _______________________________________

Date ________________________________