NORTHFIELD PUBLIC SCHOOLS #659

SCHOOL HEALTH SERVICES

PARENT REQUEST FOR GIVING OVER THE COUNTER MEDICATION AT SCHOOL

_____ may receive _____ for
Student name Medication

_____. Dose _____ . How often_____ .
Reason

This form will be used during the _____ school year, only.

I am to bring a bottle of the medication to the school for my child.

Signature _____ School _____

Date _____ Grade/Teacher _____

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