## OVER THE COUNTER/SHORT TERM MEDICATION ORDER

| 1                | COMPLETE    |  |                   |             |
|------------------|-------------|--|-------------------|-------------|
|                  |             | s/Guardians  |                   |             |
|                  |             | ne counter medication must: oplied in the original container |                   |             |
|                  |             | the dosage stated on the label                               |                   |             |
|                  |             | he expiry date clearly visible a                             | nd not be expired |             |
|                  |             | e requested must not exceed t                                |                   |             |
| s <sup>.</sup>   | TUDENTS NA  | ME   |                   |             |
|                  | DATE OF BIR |  |                   |             |
| NAME (           | OF MEDICATI | ION  |                   |             |
|                  | OSE REQUIR  | PEN  |                   |             |
|                  | R MEDICATI  | ON   |                   |             |
|                  |             | g administration of the above                                |                   |             |
| Full Name        |             |  |                   |             |
| Relationship to  | o Child     |  |                   | <del></del> |
| Contact Numb     | er          |  | -                 |             |
| Signature        |             |  |                   |             |
| •                |             |  |                   |             |
| )ate             |             |  |                   |             |
| Date             |             |  |                   |             |
|                  |             |  |                   |             |
| NURSE/FIRST      |             |  |                   |             |
| Oate NURSE/FIRST | AIDER TO CO | OMPLETE   Medication   | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |
| NURSE/FIRST      |             |  | Dose              | Signature   |