



### Short Term Medication Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

To School Nurse and/or Office Staff:

Please administer the following medication to my child as indicated:

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

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

Time: \_\_\_\_\_

For (circle days):

14 days

10 days

7 days

5 days

Today only

Other \_\_\_\_\_

Note: The Short Term Medication Form is good for a Maximum of two weeks.

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Parent/Guardian Signature

All medication must be in the original prescription bottle. No over the counter medication is given without a doctor's order and must be in a new unopened bottle.