

**Generic Request for
Administration of Medication by School****20** ___ - ___ *School Year**Date submitted to the office:*

20 ___ - ___ - ___

Complete this form if you require school staff to administer any over-the-counter or prescription medications for your child.

One form is required per student per year.

Student name _____

School year 20___ - 20___

Grade _____

Other information: _____

By signing this form, I, undersigned parent:

Authorize the staff at Ahlul-Bayt Islamic School to administer over-the-counter and prescription medication to my child upon my request throughout this school year.

Agree to provide ALL medication in original packaging or pharmacy labeled container.

- All medication must be labeled with the student's name and the name of the drug.
- Prescription medication packaging must also be labeled with the time to be taken.

Agree to provide verbal confirmation to the school office for every medication.

Parent's name _____

Parent's signature _____

Date _____

This form is also available for download from the school's website www.abischool.com