The Dominican
COMMUNITY of SCHOOLS

Date: _____

Student: _____ Teacher and Grade:_____

Medication name: _____

Dates to be administered and directions (Please include time and amount):

_____

_____

Parent Name and Signature: _____

SAA-SDS representative Name and Signature: _____

***This form is only for OTC medications. Any prescription medication **MUST** be turned-in to the school nurse. ***

Date: _____

Student: _____ Teacher and Grade:_____

Medication name: _____

Dates to be administered and directions (Please include time and amount):

_____

_____

Parent Name and Signature: _____

SAA-SDS representative Name and Signature: _____

***This form is only for OTC medications. Any prescription medication **MUST** be turned-in to the school nurse. ***