Student's Name ____DOB______________________

Who lives with parent/guardian at____

In Nashua, New Hampshire 0306__

Teacher/Advisor_________________________________School____________________Grade________

Name of Medication ____

We feel that our child may benefit from the following over-the-counter medications (not to include herbal preparations or dietary supplements) and wish to have an appropriate person assist our child in taking the medication furnished by us in accordance with the printed instruction on the manufacturer's labeled bottle we have provided. We understand that if a high dose than what the manufacturer recommends is needed, that a doctor's note, so authorizing the increased dosing will be provided by our child's medical