SCHOOL HEALTH SERVICES

OVER-THE-COUNTER/NON-PRESCRIPTION MEDICATION CONSENT FORM

Requires renewal at the beginning of each school year

Name of Student ______________________________ D.O.B. ______________

Address ______________________________ Telephone ______________

Parent/Guardian Name ______________________________

School ______________________________

Name of medication ______________________________

Dose ______________________________

Frequency______________________________

Reason to give medication______________________________

Over-The-Counter Medication

I authorize school staff to administer the above over-the-counter/non-prescription medication to my student while at school and relieve the school district and personnel of all responsibility. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I understand that the medication must be in the original container and the medication dose must be according to the label.

Parent/Guardian Signature ______________________________ Date ______________