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 _____

Reviewed by Jennifer Millage, RN 1/24/2025