



**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 \_\_\_\_\_