

# OVER THE COUNTER MEDICATION

## PARENT/GUARDIAN MEDICATION CONSENT FORM (Please type or print)

Full name of child to be medicated: \_\_\_\_\_

Name of drug and dosage: \_\_\_\_\_

Hour(s) medication to be given: \_\_\_\_\_ Number of Days: \_\_\_\_\_

Name of physician prescribing medication: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of person(s) who will be giving medication during school hours: \_\_\_\_\_

Principal or Principal's designee

(to be filled out by school principal or nurse)

I hereby give permission to the above named persons to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the School, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address