Harrisburg School District 41-2
School Health Services

Elementary- Cough Drops Only

MEDICATION SELF–ADMINISTRATION CONSENT FORM
(OVER–THE–COUNTER/NON–PRESCRIPTION MEDICATION)

Requires renewal at the beginning of each school year

Name of Student_____ DOB_____
Address_____ Telephone_____
Parent/Guardian Name_____
School_____
Name of Medication_____
Dose_____

ELEMENTARY

I authorize my child to take over-the-counter/non-prescription cough drops 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 cough drops. I understand that my child shall possess only the number of cough drops necessary for school hours or the school event or activity for one day.

GRADES 6-12

Over-The-Counter Medication

I authorize my child to take the above over-the-counter/non-prescription medication **(THIS DOES NOT INCLUDE CHEMICAL/HOMEOPATHIC SUBSTANCES AND COMPOUNDS, INCLUDINGBUT NOT LIMITED TO NATURAL REMEDIES, HERBS, AND VITAMINS)** 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 my child shall possess only the number of does(s) necessary for school hours or the school event or activity for one day.

Parent/Guardian Signature_____ Date_____

Students are prohibited from transferring, delivering, or receiving any medication to or from another student. All violations will result in confiscation of the medication and subject student(s) to discipline in accordance with the District's discipline policy. Students who use medication for purposes other than for its intended use will be disciplined and will no longer be allowed to carry and self-administer medications.