Parent/Guardian Consent for Over the Counter Medication

Student's Name: ___________________________________ DOB: __________________
Address: ____ Grade: _________________

Parent/Guardian's Name: Father: ________________ Mother: ________________
Home Telephone Number: Father: ________________ Mother: ________________
Cell Phone Number: Father: ________________ Mother: ________________
Work Number: Father: ________________ Mother: ________________
Other person to notify in case of emergency:
Name:_____________________ Relationship: _________________ Phone: ________________

Name of licensed prescriber,
(If applicable): _____________________________________ Phone: ______________________

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentially)

____

My son/daughter has the following food or drug allergies:

____

I consent to have the school nurse or personnel designated by the school nurse to administer the following medication, if needed, on field trips:

____
Medication Amount Time to be given

____
Medication Amount Time to be given

I give my permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate. Yes_________ No _________

I give my permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines is appropriate for my son/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; *however, the medication will be destroyed if not picked up within one week following the termination of the order or one day beyond the close of school.*

Parent/Guardian Signature: _________________________________ Date: __________________

Relationship to Student: ____