OVER-THE-COUNTER MEDICATION CONSENT FORM
FOR WILD ROSE SCHOOL DISTRICT

Student Name:_____ DOB:_____ Grade:_____

Parent/Guardian to complete this form and provide the over-the-counter medication (non-prescription) in the original manufacturer's package. The package must list the active ingredients and recommended therapeutic dosage. If a dosage is requested that is higher than the recommended therapeutic dosage it must be accompanied by the written approval of the student's health care provided as well as the parent/guardian's permission.

Name of Over-the-Counter Medication:_____

Reason to Administer:_____

Dose and Route:_____

Frequency/ Time to be given:_____

Start Date:_____ Stop Date:_____

Possible Side Effects:_____

_____

I hereby give permission to school personnel to administer the over-the-counter medication listed above, to my child, according to the directions provided on this form. I agree to hold the Wild Rose School District and school personnel harmless in any and all claims arising from the administration of this medication at school.

Signature of Parent/Guardian_____ Date_____

Wild Rose Middle/High School
PO Box 276
Wild Rose, WI 54984
Tele: 920-622-4201
Fax: 920-622-4801

Wild Rose Elementary School
PO Box 119
Wild Rose, WI 54984
Tele: 920-622-4204
Fax: 920-622-4601

Pleasant View School
N5275 County Road NN
Pine River, WI 54965
Tele: 920-987-5123
Fax: 920-987-5136

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