

Department of Specialized Services
Nursing

6620 W. Capitol Dr. Milwaukee, WI 53216 (414) 438-3648 • mps.milwaukee.k12.wi.us

Non-Prescription (OTC) Medication Parent Consent Form

NAME OF STUDENT	DOB:	
MEDICATION		
DOSAGE		
TIME TO BE GIVEN		
PERIOD / LENGTH OF TIME TO BE GIVE	N	
REASON FOR TAKING MEDICATION		
I authorize the above-stated medication be give	ven, as indicated, to my son / daughter.	
Date	Signature of Parent / Legal Guardian	
Reviewed by Nurse/Building Designee:		
 Date	Signature of Nurse/Building Designee	

Start. Stay. Succeed.
Comienza. Quédate. Triunfa.