



Non-Prescription (OTC) Medication Parent Consent Form

NAME OF STUDENT _____ DOB: _____

MEDICATION _____

DOSAGE _____

TIME TO BE GIVEN _____

PERIOD / LENGTH OF TIME TO BE GIVEN _____

REASON FOR TAKING MEDICATION _____

I authorize the above-stated medication be given, as indicated, to my son / daughter.

Date

Signature of Parent / Legal Guardian

Reviewed by Nurse/Building Designee:

Date

Signature of Nurse/Building Designee