Health Department
729 Clay Street
Darlington, WI 53530
P. 608-776-4895
F. 608-776-4885

MEDICATION ADMINISTRATION CONSENT FORM: Over the Counters

Student Name:_____ Grade/Teacher:_____

Birth Date:_____ Allergies:_____

NOTE TO PARENTS/GUARDIANS
The School District **REQUIRES** that students who need over-the-counter medication during school hours **MUST** do the following:

1. Present a written consent form filled out and signed by the parent or legal guardian. (Consent form below)
2. Bring over-the-counter medication in the original container. Do not send medication in plastic baggies, envelopes, or other unmarked containers.

NOTE: Many of the short-term medications do not need to be given at school. For example medication taken 3 times per day can be given in the morning before school, right after school, and at bedtime.

CONSENT FOR MEDICATION OVER-THE-COUNTER MEDICATION

Medication:_____ Dosage:_____

Time to be given:_____

Reason for Medication to be given:_____

By signing below, I give school personnel permission to administer the above indicated non-prescription medication to my son/daughter. I understand that all medication should be in their original container. I give permission that necessary information related to my child's condition be shared with the school nurse

_____

Parent Signature Date