

Parent /Guardian Consent for OVER THE COUNTER MEDICATION

Student's Name: _____ DOB ___ / ___ / ___

Address: _____ Grade: _____

Parent/Guardian name: Father _____ Mother _____

Telephone number (home): Father _____ Mother _____

Telephone number (work): Father _____ Mother _____

Cell number: Father _____ Mother _____

Other person(s) to notify in case of emergency:

Name: _____ Telephone number _____

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

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

I consent to have the school nurse or school personnel designated by the school nurse administer the following medication:

Acetaminophen (Tylenol)	1-2 tablets	Per weight of	
Ibuprofen (Advil)	1-2 tablets	student	When needed by the student
Bismuth (PeptoBismol)	1-2 tablets		
Antacid (Tums)	1-2 tablets		

NAME OF MEDICATION	AMOUNT	TIME TO BE GIVEN
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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 appropriate for my son's/daughter's health and safety.

I understand that I may retrieve the medication from the school at any time; *however, the medication will be destroyed if it is 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 _____