SCHOOL HEALTH SERVICES

MEDICATION SELF-ADMINISTRATION CONSENT FORM

(OVER-THE-COUNTER / NON-PRESCRIPTION MEDICATION)

Requires renewal at the beginning of each school year

Name of Student _____ D.O.B. _____

Address _____ Telephone _____

Parent/Guardian Name _____

School _____

Name of medication _____

Dose _____

ELEMENTARY

I authorize my child to take over-the-counter/non-prescription cough drops while at school and relieve the school district and personnel of all responsibility. I understand that the school district and individuals involved will not be held liable for any adverse effects of the cough drops. I understand that my child shall possess only the number of cough drops necessary for school hours or the school event or activity for one day.

GRADES 6-12

Over-The-Counter Medication

I authorize my child to take the above over-the-counter/non-prescription medication while at school and relieve the school district and personnel of all responsibility. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I understand that my child shall possess only the number of dose(s) necessary for school hours or the school event or activity for one day.

Parent/Guardian Signature _____ Date _____

Students are prohibited from transferring, delivering or receiving any medication to or from another student. All violations will result in confiscation of the medication and subject student(s) to discipline in accordance with the District's discipline policy. Students who use medication for purposes other than for its intended use will be disciplined and will no longer be allowed to carry and self-administer medications.