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	
and personnel of all responsibility. I understand that the so	ion cough drops while at school and relieve the school district chool district and individuals involved will not be held liable for nat my child shall possess only the number of cough drops or one day.
GRADES 6-12	
Over-The-Counter Medication	
district and personnel of all responsibility. I understand th	n-prescription medication while at school and relieve the school at the school district and individuals involved will not be held tand that my child shall possess only the number of dose(s) or 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.