Consent for Over-The-Counter Medication Administration
District 511

ALL OTC MEDICATION REQUIRES A PARENT/GUARDIAN SIGNATURE

Student: _____ Date of Birth:_____ Grade: _____

School: [ ] Elem [ ] Middle [ ] Sr. High School Year: _____

Parent/Guardian Name: _____ Phone: (H) _____ (W) _____

1. **Reason** for medication/treatment: _____

2. Name of **Medication:** _____ **Dosage:** _____

( ) tablet/capsule ( ) liquid ( ) inhaler ( ) nebulizer ( ) other

3. **Time** mediation is to be given **AT SCHOOL**: _____ ( ) with lunch

4. Start Date: _____ until ( ) end of school year, ( ) further notice from parent

I authorize school personnel to set-up and administer the above medication to my child (unless administration/self carry has been indicated). I understand that the **medication must be properly labeled in a manufacturer container.** Medication in plastic bags or white envelopes WILL NOT be accepted. OTC excludes medications containing ephedrine or pseudoephedrine listed as their active ingredients.

***This notice gives permission for the school health office to share information regarding this student's health condition to better care for the child during school hours.

_____ _____

Parent/Guardian Signature **Date**