Waunakee Community School District
OVER-THE-COUNTER MEDICATION CONSENT FORM
(Each medication requires a separate form)

TO BE COMPLETED BY THE PARENT/GUARDIAN:

Student Name:	DOB:
School:	Grade:
Diagnosis:	Over-the-counter Medication:
Dose:	Frequency/Times:
Start Date:	Stop Date:
Possible Side Effects:	

PARENT/GUARDIAN CHECK ONE:

Over-the-Counter Medication Administered By Authorized School Personnel

☐ I give my permission to authorized school personnel to administer to my child the over-the-counter medication listed above according to directions provided on this form. I agree to hold the Waunakee Community School District and authorized staff harmless in any events arising from the administration of this medication. I agree to notify the school in writing of any changes in the above order.

Over-the-Counter Medication Is To Be Self-Administered By The Student

☐ This over-the-counter medication will be self-administered. I have reviewed the proper method of administration (storage of medication, dosage, date(s) and time(s) to be taken, and possible side effects) with my child. I request my child be able to carry and self-administer this medication independently. I understand the school district does not accept any responsibility for the self-administration of over-the-counter medication, including, but not limited to, the administration, supervision, or documentation thereof.

Parent/Guardian Signature:	Date:
Telephone (home):	Telephone (work):

Parent/guardian signature is required for over-the-counter medication administration.

Authorized school personnel must document medication they administer on the medication record/flow sheet.