ROCORI AREA SCHOOLS
ISD #750

Parental/Guardian Request for Non-Prescription Medication Administration

Student's Name: _____ Birth Date: _____

Grade: _____ School Year: _____

School: _____

Consent for Administration of Over-The-Counter (OTC) Medication

(To be completed by Parent/Guardian)

Medications: check the medications/creams that you approve of

- Tylenol 500-1000mg's _____
- Ibuprofen 400mg's _____
- Excedrin 1-2 tabs _____
- Hydrocortisone cream_____
- Antibiotic cream_____
- Benadryl Itch cream/Spray_____
- Other: List out medication name and dose: _____

Route of Administration: _____

Dosage of Medication: _____

Frequency or Time Schedule: _____

I understand I must provide this medication in the original, properly labeled bottle. I release school district #750 and any school personnel from any liability in relation to the administration of this medication at school.

_____ _____

Parent/Guardian Signature Date