

AGUA FRIA UNION HIGH SCHOOL DISTRICT

PARENT'S CONSENT FOR GIVING NON-PRESCRIPTION

(OVER THE COUNTER) MEDICATION AT SCHOOL

I hereby request and give my consent for the school nurse or person designated by the administrator to see that my child _____ Grade _____
Receives the following medication for the period from _____ to _____

The medication is to be furnished by me in the original container and is to be labeled with and given in the following manner:

1. Name of medication _____
2. Route of administration (by mouth, etc) _____
3. Amount to be given _____
4. Time of day to be taken _____
5. Expected duration of treatment _____
6. Indication (reason) _____

Allergies to medications: NO _____ YES _____ Please list _____

Signature of Parent/Guardian _____ Date _____

COMMENTS:

Nurse's Signature and Title _____ Initials _____

Paraprofessional Signature and Title _____ Initials _____

THE SCHOOL NURSE MUST BE NOTIFIED IMMEDIATELY IN WRITING OF ANY CHANGE IN MEDICATION.

Count _____ Date _____

Count _____ Date _____