MILWAUKEE PUBLIC SCHOOLS

# Non-Prescription (Over-The-Counter) Medication Consent Form

Name of Student: _____

Medication: _____

Dosage _____

Time to be Given _____

Start Date – End Date _____

Reason for Taking Medication _____

If the parent/legal guardian's request for the over-the-counter medication exceeds the therapeutic recommended dose, then the student's health care provider must authorize and sign a Medication/Procedure Authorization form.

I am responsible for bringing the over the counter medication(s) to school in an original labeled container. I also understand that I am responsible for maintaining a sufficient amount of medication(s) at the school. Failure to do so will result in an interruption or discontinuation of medication administration for my child. I understand that, if my child refuses to take the over the counter medication, force will not be used by school personnel to make my child comply.

Signature of Parent/Legal Guardian Phone Number Date: (Month/Day/Year)