PORT WASHINGTON-SAUKVILLE SCHOOL DISTRICT

We educate all children to reach their greatest potential.

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Non-Prescription (OTC) Medication Parent Consent Form

*Medications must be administered in accordance with the instructions on original packaging label.

NAME OF STUDENT_____
DOB: _____

MEDICATION_____

DOSAGE_____

TIME TO BE
GIVEN_____

PERIOD / LENGTH OF TIME TO BE
GIVEN_____

REASON FOR TAKING
MEDICATION_____

_____

I authorize the above-stated medication be given, as indicated, to my son / daughter.

_____ _____
Date Signature of Parent / Legal Guardian

Reviewed by Nurse/Building Designee: