School District of South Milwaukee
Over the Counter Medication Administration Consent/Instructions
(Confidential)

Student Name: _____ School: _____

Address: _____ Phone: _____

Parent/Guardian Statement

I hereby request and authorize that _____ receive medication from a school staff member as appointed by the School Principal. I shall supply the school authorities with a properly-labeled bottle of medication. I understand that the school is not responsible for the loss of medication due to carelessness of the student while transporting the medication to school. (Permission may be given to the District Nurse over the telephone).

A. Name of Medication _____
B. Purpose _____
C. Dosage _____
D. Frequency _____ Time of administration _____
E. Special instructions _____
F. Side effect(s) to be alert for _____
_____

These instructions are valid until _____, but do not exceed the end of the school year.

_____ _____ _____
Parent/Guardian Signature Date Received By