Lancaster Community School District

Students

PARENT/GUARDIAN OVER-THE-COUNTER MEDICATION CONSENT FORM

Full name of student _____

Name of drug and dosage _____

Hour medication is to be given _____

Phone number of parent or guardian_____

Reason for medication _____

Name of person who will be giving the medication during school hours will be

_____

(To be filled out by the principal or nurse)

- I hereby give my permission to the above-designated person to give the medication to my child according to the directions stated above and to contact the child's practitioner.
- I further agree to hold the (Lancaster Community School District) and above designated person harmless in any and all claims arising from the administration of this medication at school.
- I agree to notify the school, in writing, at the termination of this request or when any change in the above orders is necessary.

_____ _____

Signature of parent/guardian Date

EXHIBIT APROVED: January 9, 1985

EXHIBIT REVISED: April 13, 2005