South Nodaway - Parent Medication Consent Form

I am requesting your assistance in giving the following medication/s to my child during the specified school hours.

Name of Student: _____ Grade: _____

Medication: _____ Dosage: _____

Time to Give: _____ Route: (Mouth, Ears, Drops, Etc) _____

Start Date: _____ Termination Date: _____

Does the medication need to be refrigerated? ☐ Yes ☐ No

I understand that I am to supply medication in the pharmacy bottle and accompanying label and instructions.

We no longer need a doctor's note for students to bring over-the-counter medicine such as ibuprophen, pain reliever, cold medicine, cough drops, etc. to the school. You are asked to bring them immediately to the school nurse who will lock them up in her office. Please bring them in their original bottle/package also.

Signature of Parent/Guardian: _____ Date: _____

Daytime Phone Number: _____

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