PARENT/GUARDIAN MEDICATION CONSENT FORM

Required by Chilton Public Schools

OVER-THE-COUNTER MEDS ONLY

_____ _____

Student's Name Date

_____ _____ _____

Grade Age Teacher

AS YOU KNOW, THE SCHOOL, BY LAW, CAN NOT ADMINISTER ANY MEDICATION, WHETHER IT BE PRESCRIPTION OR OVER-THE-COUNTER, TO STUDENTS WITHOUT THE APPROPRIATE PAPERWORK ON FILE. Please complete this form and return it to school, along with the medication in it's **ORIGINAL BOTTLE/PACKAGE.**

Name of Medication_____

Dosage of Medication and Time of Day to be Given_____

_____

_____

I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the written instructions as filled out above.

I further agree to hold the Chilton School District and all employees 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 is necessary. (**PLEASE NOTE: ANY MEDICATION BROUGHT TO SCHOOL MUST BE IN ITS ORIGINAL BOTTLE/PACKAGE.)**

_____ _____

Parent/Guardian Signature Phone number where you can be reached