DICKINSON PUBLIC SCHOOLS

OVER-THE-COUNTER MEDICATION-PARENTAL SIGNATURE ONLY NEEDED

NON-SELF ADMINISTERING MEDICATION CONSENT FORM

FOR ANY OVER-THE-COUNTER MEDICATION THAT WILL BE ADMINISTERED BY SCHOOL STAFF ACCORDING TO PACKAGE DIRECTIONS.

Name of Student _____D.O.B._____
Address_____School_____
Parent/Guardian's Name _____
Phone- Home _____ Cell _____ Work_____
Emergency Contact (other than parent) _____
Phone- Home _____ Cell _____ Work_____

OVER-THE-COUNTER MEDICATION

Name of medication/treatment_____
Dose_____
Allergies _____
Comments _____

Parent Consent

I authorize my child to receive the above medication while at school and relieve the school district and personnel of all responsibility. I authorize the school's designated medication provider to provide the medication to my child. I acknowledge that I have read, understand, and agree to comply with the School District's medication program policy. I certify that the information included on this form is accurate to the best of my knowledge. I certify that medications I have authorized the school to provide to my child do not, to my knowledge, interact, and I certify that my child is not known to be allergic to them. I understand and hereby release Dickinson Public School District and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

_____ _____ _____
Name of Parent/Guardian (please print) **Signature of Parent/Guardian** **Date**