

NRHEG Public School ISD #2168
**Consent for Administration of OTC
Medication Form**



Rev. 2-2-2024

Student Name _____ Birth date _____

Grade _____ Teacher _____

For Non-Prescription/Over-the-Counter Medication:

(acetaminophen, ibuprofen, antacid, cough drops, etc.)

*****MEDICATION MUST BE BROUGHT IN AND SUPPLIED IN ORIGINAL CONTAINER FOR ADMINISTRATION*****

1. I request that the medications listed below be given to my child, as needed, during school hours.
2. I release school personnel from any liability in relation to the proper administration of this medication at school. (administration of this medication will be done by the school nurse or staff member designated by the school nurse)
3. I understand I must supply the medication in the original container and it will be kept in the health office.
4. I understand over-the-counter medications may not be administered in excess of label recommendations unless a physician order is received.
5. I understand that non-FDA approved medications will not be given.

Medication	Dosage	Time	Duration
1. _____			
2. _____			
3. _____			
4. _____			

Signature of parent/guardian: _____ Date _____