PARENTAL CONSENT FORM TO DISPENSE OVER-THE-COUNTER MEDICATION

I HEREBY REQUEST AND GIVE MY CONSENT FOR THE FRONT OFFICE NURSE OR OTHER DESIGNATED STAFF TO DISPENSE THE OVER-THE-COUNTER MEDICATION(S)* NOTED BELOW TO MY CHILD:

_____

(Please Print Full Name of Student)

*Please complete Prescription Authorization form if any prescription drugs are necessary at any time.

The following over-the-counter medications may be dispensed to my child:	
☐	**Cough Drops**
☐	**Acetaminophen (Tylenol)** *Dosage:_____*
☐	**Antacid (TUMS)** *Dosage:_____*
☐	**Pepto-Bismol** *Dosage:_____*
☐	**Benadryl Itch-Stopping Gel** *(Diphenhydramine Hydrochloride Topical Analgesic)*

The medications listed below must be furnished by parent(s) in the original container with the dosage instructions.	
☐	**Antihistamine / Allergy medication** *Dosage:_____*
☐	**Cough Suppressant / expectorant** *Dosage:_____*
☐	**Ibuprofen (Advil, Motrin)** *Dosage:_____*
☐	**Aspirin** *Dosage:_____*

☐ DO NOT dispense over-the-counter medication to my child.

Is your child allergic to food or other substances (medications, latex, ointments, etc.) (If *yes*, please describe symptoms and name substances to be avoided)	**No** ☐	**Yes** ☐
Please describe the procedure to follow if allergic reaction occurs:		
Is your child usually susceptible to infections and if so what precautions need to be taken?	**No** ☐	**Yes** ☐
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, asthma, etc.)**?**	**No** ☐	**Yes** ☐
Comments		
Other Special Instructions		

EMERGENCY CONTACT INFORMATION

Student Name	Date of Birth	Sex M / F	Phone
Home Address	City	State	Zip

Mother or Guardian Name	Home Phone	Cell Phone	Work Phone
Home Address	City	State	Zip
Mother or Guardian Name	Home Phone	Cell Phone	Work Phone
Home Address	City	State	Zip

The following individuals are OKAY TO PICK-UP my child from the facility:

Full Name	Relationship to Student	Address (#, Street, City, State, Zip)	Phone
Full Name	Relationship to Student	Address (#, Street, City, State, Zip)	Phone
Full Name	Relationship to Student	Address (#, Street, City, State, Zip)	Phone
Full Name	Relationship to Student	Address (#, Street, City, State, Zip)	Phone

The following individual(s) may NOT remove my child from the facility:

List Name(s) & Relationship to Student

Custody papers have been provided and are on file at the facility: ☐ **YES** ☐ **NO**

If medical care is necessary, CALL:

DOCTOR	Name	Address	Phone
HOSPITAL	Name	Address	Phone

This EMERGENCY INFORMATION and MEDICAL CONSENT FORM is complete and accurate, front and back, and was provided by:

_____ _____ _____

(Parent PRINTED Name) *(Parent Signature)* *(Date)*