Agua Fria Union High School District
Consent to Administer Non-Prescription (OVER THE COUNTER) Medication at School

Check School: ✓

______

______

______

______

Student Name: ____ Date: ______________
(PRINT) Last First Middle

Grade: 9 10 11 12 Date of Birth: ______________

As parent/guardian of the above-named child, I hereby request and give my consent for the school nurse or person designated by the school administration to see that the above-named student receives the following OVER THE COUNTER medication for the period from _____/_____/_____ to _____/_____/_____.

The OVER THE COUNTER medication is to be provided by parent/guardian to the school nurse in the original labeled container with and given in the following manner:

Name of OVER THE COUNTER Medication: ____

Amount Will Be Given As Directed On The Bottle: ____

Time of Day to be Administered: ____

Expected Duration of Treatment: ____

Reason for OVER THE COUNTER Medication: ____

Comments: ____

____

____

Parent/Guardian (Print Name): ____

Parent/Guardian Signature: ____ Date: ______________

Phone Number Where Parent/Guardian Can Be Reached: ____