Port Edwards Public Schools
801 Second Street
Port Edwards, WI 54469
Phone: 715-887-9000
www.pesd.k12.wi.us

Parent/Guardian Non-Prescription Medication Consent Form

Name of Student_____ Date of Birth:_____Grade_____

I give permission for my son/daughter to receive medication during school hours and during school sponsored activities/field trips that occur after hours. I will be responsible for:

1. Delivery of medication: Non-prescription medication must come to school in the original manufacturer's packaging, labeled with the student's name and delivered by the parent/guardian. The recommended therapeutic dose on the package will be followed unless otherwise indicated by the parent/guardian below.
2. Maintaining a sufficient supply of medication. Empty bottles will be disposed of by school staff unless informed otherwise.
3. Keeping school personnel informed of changes in the medication (dosage,time)
4. Understanding that the above information may be shared with necessary school personnel.

I hereby release the board of education & its employees from any liability that results from my child taking this medication. I understand that non-prescription medication will only be administered if it is FDA approved & may be administered by non-medically trained personnel. I'm aware that any non-prescription medication intended for long term use on a daily basis must be accompanied by a provider's signature. I understand that this medication consent is good for the entirety of the school year (and summer school if needed) unless I notify health office staff. My signature indicates that I have fully read and understand the above information.

Medication: _____ Dose:_____

Time: _____ Route: _____(oral, nasal, etc)

Medication to be administered for the following conditions:

- ☐ Headache
- ☐ Sore Throat
- ☐ Mild Musculoskeletal Pain
- ☐ Fever
- ☐ Menstrual Cramps
- ☐ Other:_____

AT THE END OF THE SCHOOL YEAR, PLEASE (check one):

Contact me to pick up remaining medication	Dispose of remaining medication	Send remaining medication home with my child

Parent/Guardian Signature:_____ Date: _____

Reviewed 5/2023