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

Parent/Guardian Medication Consent (Non-Prescription Medications Only)

Date:_____

Student Name:_____ Grade:_____Birth Date:_____

Non- prescription medication (over-the-counter) which is FDA approved can be administered. A written, signed statement from the parent/guardian must be on file at school authorizing school personnel to administer.

Non- prescription drugs must come to school in the original manufacturer's packaging (original container)with ingredients and recommended therapeutic dose with the student's name on the container.

Any non-prescription medication intended for long - term use on a daily basis must be accompanied by a practitioner's signature.

All medication must be supplied by the parent.

I give my permission for the following medication to be given to my son/daughter by designated School Personnel:

Medication: _____ Dosage:_____ Time:_____

Route: Oral Topical Eye Drops Ear Drops Cough Drops

Administered for the following conditions:*check all that apply*

_____Headache _____Common Cold Symptoms ____Mild Musculoskeletal Pain
_____ Fever _____Sore Throat ____Menstrual Cramps
Other:_____

This order will be in effect for the current school year. I agree to notify the school personnel in writing at the termination of this request or when any change in the above consent is necessary.
I agree to hold the Port Edward School District and authorized school personnel harmless in any and all claims arising from the administration of this medication at school .

Parent/Guardian Signature:_____ Date:_____

Address: _____ Contact # : _____