# Amelia County Schools

## OVER-THE-COUNTER MEDICATION CONSENT FORM

### TO BE COMPLETED BY THE PARENT/GUARDIAN:

| | | |
|---|---|---|
| Student's Name | School | Grade |
| Diagnosis | | |
| Over-the-Counter-Medication | | |
| Dose | Frequency/Times | |
| Start Date | Stop Date | |
| Possible Side Effects | | |

### Over-the-Counter Medication Administered By Authorized School Personnel

☐ I give my permission to authorized school personnel to administer to my child the over-the-counter medication listed above according to directions provided on this form. I agree to hold the Amelia County School District and authorized staff harmless in any events arising from the administration of this medication. I agree to notify the school in writing of any changes in the above order.

| | |
|---|---|
| Parent/Guardian Signature | Date |
| Telephone (home) | (work) |

*Parent/guardian signature is required for over-the-counter medication.*