

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.