



MINERAL POINT SCHOOLS

Student Name _____ Date of Birth _____ Grade _____

NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION PERMISSION AND INSTRUCTION FORM

MEDICATION _____

DOSAGE _____

(if more than therapeutic dose on packaging, must have medical provider signature as well)

TIME TO BE GIVEN _____

PERIOD/LENGTH OF TIME TO BE GIVEN _____

REASON FOR TAKING MEDICATION

I AUTHORIZE THAT THIS MEDICATION BE GIVEN AS INDICATED TO MY SON/DAUGHTER

(Signature of Parent)

(Date)

Parent/Guardian signature is required for this form to be valid.

*****Please bring the medication to school in its original container labeled with your child's name.*****

Revised 8/24/22