Over-the-Counter Medication Consent Form

Student/Recipient Information

Full Name

Date of Birth

Grade/Class

Parent/Guardian Name

Contact Number

Medication Information

Medication Name

Dosage

Frequency

Route

Reason/Purpose for Medication

Known Allergies

Consent

I hereby give permission for the above-named individual to receive the listed over-the-counter medication as directed.

Parent/Guardian Signature

Date