LCA MEDICATION CONSENT FORM

Over-the-Counter Medication

Please complete this form and return it to the nurse's office, attached to any medication that your child may need during the school day.

Student Name: _____ Age_____ Grade_____

Name of Medication: _____ Allergies: _____

Dosage: _____ Frequency: _____

Reason for medication: _____

Effective dates: from _____ to _____

I give my consent for LCA staff to dispense the above medication (s) to my child.

_____ _____

Parent Signature Date

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