Arrowhead Union High School District
Over-the-Counter (OTC) Medication Consent Form

Student Name:	Graduation Year:

Parent/ Guardian Medication Consent:

I understand that it is my responsibility to:

1) **Supply the health room with a bottle/box of medication properly labeled with the student's name, in its <u>ORIGINAL</u> packaging, and not expired. Medication MUST be stored in the health room.**
2) **Verify that the instructions for use do not exceed the manufacturer's recommended dosages. Any dosing requests above manufacturer's recommendations need a physician's order.**
3) **Provide refills upon request.**
4) **Provide written notification to the health room if any change are made or if the medication is discontinued.**
5) **Pick up medication at the end of the year. Any medication not picked up by the parent the last day of school will be discarded by the health room.**

I, hereby, give permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my student according to the directions listed below. I further agree to hold the Arrowhead School District, and the above identified person(s) harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school. I understand that self-administration, and self-carry of non-prescription medication is not permitted. I agree to notify the health room at the termination of his request or when any change in the below order is necessary. This form is valid for the school year in which it is provided during.

Parent/ Guardian Signature:

Date:

Medication Information:

Name of Medication:	Reason for Use:	Dosage and Frequency:
	Time to be Given: (Example: As Needed or Indicate a Time)	**Route:** (Example: Oral, Inhalation, Eye, Ear, Nasal, Topical)