MILWAUKEE
PUBLIC SCHOOLS

Department of Specialized Services
Nursing
6620 W. Capitol Dr.
Milwaukee, WI 53216
(414) 438-3648 • mps.milwaukee.k12.wi.us

Non-Prescription (OTC) Medication Parent Consent Form

NAME OF STUDENT_____ DOB: _____

MEDICATION_____

DOSAGE_____

TIME TO BE GIVEN_____

PERIOD / LENGTH OF TIME TO BE GIVEN_____

REASON FOR TAKING MEDICATION_____

_____

I authorize the above-stated medication be given, as indicated, to my son / daughter.

_____ _____
Date Signature of Parent / Legal Guardian

Reviewed by Nurse/Building Designee:

_____ _____

MILWAUKEE
PUBLIC SCHOOLS

Signature of Nurse/Building Designee

Department of Specialized Services
Nursing
6620 W. Capitol Dr.
Milwaukee, WI 53216
(414) 438-3648 • mps.milwaukee.k12.wi.us