SHEBOYGAN CHRISTIAN SCHOOL

929 Greenfield Ave, Sheboygan WI 53081 (920) 458-9981 Fax: (920) 458-9957

PARENTAL AUTHORIZATION AND RELEASE FORM FOR OVER-THE-COUNTER MEDICATION

Full name of Student _____ Grade _____

I hereby give permission for school personnel to administer medications(s) to my child according to the directions below. I am responsible to provide the medication in the original container. I understand that any unused medications will be properly disposed of within ten days if not claimed after discontinuation of the medication.

_____ _____

Signature of Parent or Legal Guardian Date

Phone number where parent can be reached if needed _____

Name of medication _____

Dosage to be given _____ Time to be given _____

Date to begin medication _____ Date to stop medication _____

Additional comments or instructions _____

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MEDICATION LOG

Date	Time	Dosage	Comments