

929 Greenfield Ave, Sheboygan WI 53081

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

Full name of Stud	dent		Grade
directions below.	I am responsible ons will be proper	le to provide the m	minister medications(s) to my child according to the edication in the original container. I understand that any not claimed after discontinuation of the medication or at the
Signature of Pare	nt or Legal Gua	ırdian	Date
Phone number wh	here parent can	be reached if need	ed
Name of medicat	ion		
Dosage to be given			Time to be given
Date to begin medication			Date to stop medication
Additional comm	ents or instruct	ions	
*****	******	******	***************
		MED	ICATION LOG
Date	Time	Dosage	Comments
		_	
		_	
		_	
		_	