OXFORD SCHOOL DISTRICT
OVER THE COUNTER MEDICATION PERMISSION FORM

I. Parent/Guardian must complete and sign this form.

II. **ALL MEDICATION MUST BE BROUGHT TO THE SCHOOL BY A PARENT/GUARDIAN AND MUST BE IN THE ORIGINAL PACKAGING.**

PARENT/GUARDIAN CONSENT

Student_____ Date of Birth_____

School_____ Grade_____

Parent/Guardian_____

Home Ph_____ Work Ph_____ Cell Ph_____

I hereby request and authorize you to allow my son/daughter to take:

Medication_____ Dose_____

Time(s): _____

Start Date: _____ Stop Date:_____

All medications will be administered according to manufacturer's recommendations.

I release school personnel from liability should reactions result from this medication.

_____

Parent/Guardian Signature Date

Revised 10/24