# Midlothian Independent School District

## Consent Form for Over-the-Counter Medications

**Student: _____ School:_____**
**Grade: _____ School Year: _____**
**Medication: _____**
**Dosage / Time to be Given: _____**
**Condition/Symptom requiring Medication: _____**
**Date of Request: _____ Date of Termination: _____**

**I, the undersigned, the parent/guardian of the student named above request that the above medication to be administered to my child. I will notify the school nurse of any medication changes.**

**_____**
***Name (printed)*** ***Relationship*** ***Parent/Guardian Signature***

**Date: _____ Home Phone: _____ Work Phone: _____**


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