



## Plan of Care-

# Non-Prescription Medication Consent Form

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This form authorizes program staff to administer non-prescription (over-the-counter (OTC)) medications to my child as indicated below. I understand that medication will be administered according to program policy and manufacturer instructions unless otherwise noted.

### Student Information:

Student Name	
Date of Birth	
Age	
Program Site / Location	
Date Plan Completed	
Review Date	

### Parent/Guardian Information:

Parent/Guardian Name:	
Phone Number:	
Emergency Contact (if different):	

### Medication Authorization

I authorize my child to receive the following non-prescription medications as needed (check all that apply): <input type="checkbox"/> Acetaminophen (Tylenol) <input type="checkbox"/> Ibuprofen (Advil/Motrin) <input type="checkbox"/> Antihistamines (Benadryl, Zyrtec, Claritin) <input type="checkbox"/> Cough Drops <input type="checkbox"/> Topical Ointments (e.g., antibiotic cream) <input type="checkbox"/> Sunscreen <input type="checkbox"/> Insect Repellent <input type="checkbox"/> Other (Please describe):	
Dosage / Special Instructions:	

### Additional information:

Additional information you want staff to know	
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### Consent Duration

Effective Date:	
Expiration Date (if applicable):	

### Acknowledgement

I understand that program staff are not medical professionals and that this authorization does not replace professional medical advice. I may revoke this consent at any time in writing.

### Parent/ Guardian Signature:

Parent / Guardian Name	
Signature	
Date	