# Parental/Guardian Request for Non-Prescription Medication Administration

Child's Name: ___________________________________ Birth Date: _____________

Consent for Administration of Over-The-Counter (OTC) Medication
(To be completed by Parent/Guardian)
Medication: ______________________________________________________________________
Route of Administration: ___________________________________________________________
Dosage of Medication: _____________________________________________________________
Frequency or Time Schedule: _______________________________________________________

I understand I must provide this medication in the original, properly labeled bottle. I release Connections, LLC and any Connections personnel from any liability in relation to the administration of this medication at school.

____________________________________ _____________
Parent Name (printed) Date

________________________________________
Parent Signature