



Non-Prescription Medication Consent

Medication must be provided in original container with dosing information.

PARENT/GUARDIAN, please complete the following:

_____ (Name of Student-Please print) _____ (Program)

I hereby request that an authorized representative of AYS administer the **non-prescription** medication listed below to my son/daughter. I understand that I may withdraw this consent at any time by submitting a written request to AYS personnel. Furthermore, I understand this consent is valid for only one school year.

_____ (Parent/Guardian Signature) _____ (Date)

Name of **non-prescription** medicine: _____

Dosage and directions for administration: _____

Purpose: _____

****If your child attends a licensed AYS program, your child's physician is also required to complete the following:**

_____ is a patient under my care. The following **non-prescription** medication would need to be administered during the AYS program. The following is a description of the medical order:

Name of the **non-prescription** medication: _____

Dosage and directions for administration: _____

Purpose:

Possible side effects to be reported: _____

_____ (Physician Signature) _____ (Date)

_____ (Physician Printed Name)