Wolf River Lutheran High School
W7467 River Bend Road, Shawano, WI 54166
(715) 745-2400 – office@woflriverlhs.org – www.wrlhs.org

OTC Medication Consent Form

Child's Name _____ *DOB* _____

Name of Medication _____ *Dosage* _____

Reason for Medication _____

I hereby give permission to authorized school staff to give the medications to my child according to the directions stated above and further authorize them to contact my child's physician if needed. I agree to hold Wolf River Lutheran High School and its employees and agents, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of medication at school.

I understand that this form will be on file for the duration of the school year unless otherwise notified.

I agree to notify the school in writing at the termination of this request or when any changes in the above medication is made.

_____ _____

Signature of Parent/Legal Guardian Date

Physician Name: _____ Phone: _____

Revised: 2/2016