

Rapid City Area Schools 51/4  
School Health Services

**SECONDARY STUDENTS**

**OVER-THE-COUNTER/NON-PRESCRIPTION MEDICATION  
SELF-ADMINISTRATION CONSENT FORM**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

**Secondary Student/Over-The-Counter Medication**

I authorize my child to take the above over-the-counter/non-prescription medication (This does not include "natural remedies", herbs, vitamins, dietary supplements or homeopathic medications. These are considered prescription medications.) while at school and relieve the Rapid City Area School District personnel of all responsibility. I understand that the school district and the individuals involved will not be held liable for any adverse effects of the medication. I understand that my child shall possess only the number of dose(s) necessary for school hours or the school event or activity for one day. I understand that this consent cannot be used at the elementary level.

**Students are prohibited from transferring, delivering or receiving any medication to or from another student. All violations will result in confiscation of the medication and subject student(s) to discipline in accordance with the district's discipline policy. Students who use medication for purposes other than for its intended use will be disciplined and will no longer be allowed to carry and self-administer medications. Consents must be completed for each medication and a new consent must be signed as the over-the-counter/non-prescription medication changes and the consent must be kept in the nurse's office.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date