



**PARENT/GUARDIAN AUTHORIZATION FOR OVER-THE COUNTER
MEDICATION**

Student's Name: _____ Date of Birth _____

We, the undersigned, are the parents/guardians of _____, who lives with us at _____.

We feel that our child may benefit from the following over the counter medications (**not to include herbal preparations for dietary supplements**) and wish to have an appropriate person assist our child in taking the medication furnished by us in accordance with the printed instructions on the manufacturer's label bottle we have provided.

Medication: _____

Dosage: _____

Frequency or time(s) of administration: _____

Reason for medication necessity: _____

Other medications being taken by student: _____

My child has the following food or drug allergies: _____

We hereby agree to indemnify and hold forever harmless all employees of the Saint Pius X School against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or brought by said minor or by anyone on behalf of said minor for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of the aforesaid assistance, and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state as against such claim for reimbursement of indemnity.

Please read the above carefully before signing. No child will be assisted in taking medication until this form has been signed and delivered to the school.

I give permission for my son/daughter to self-administer medication, if the School Nurse determines it is safe and appropriate. _____ Yes _____ No

I consent to have the School Nurse or school personnel designated by the School Nurse administer over-the-counter medications.

Parent/Guardian Signature _____ Date _____

Relationship to Student _____

ALL MEDICATIONS MUST BE SUPPLIED BY PARENT