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: ____

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We hereby agree to indemnify and hold forever harmless all employees of the St. 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: ____

Health Office Authorization: ____

ALL MEDICATIONS MUST BE SUPPLIED BY PARENT