St. Joseph Catholic School
Authorization for Administration of Non-Prescription Medication
2018-2019

Student Name: _____Grade:_____

Parent/Guardian: _____ Daytime Phone#_____

I (We) as parent/guardian of the above named student authorize the personnel of St. Joseph Catholic School to give my child the following **non-prescription medication** should it be necessary. Dosage instructions from the bottle/container will be followed, unless otherwise specified by parent.

Please indicate the following that apply:

1. Ibuprofen (Motrin, Advil) _____
2. Tylenol (Acetaminophen) _____
4. Cough Drops _____
5. Benadryl (will contact guardian prior to giving) _____
6. Tums_____
7. Topical ointment (Neosporin, triple antibiotic ointment, hydrocortisone) _____

Other medication my child may take with complete instructions (examples: decongestants, cough medicine, antacids)
Name of Medication(s)_____

Medical Management Plan? Yes No
(Required for asthmatic, anaphylactic and diabetic medications)

I (We) understand that if this form is not signed and returned to the school office, my child will not be given any medication at school. I (We) understand that all medications will be turned in to and stored in the office, unless a Medical Management Plan has been completed granting my (our) student permission to carry emergency medications on their person. I (We) accept ultimate responsibility for monitoring the effects and possible adverse reactions of these medications on my (our) child. I (We) therefore release St. Joseph Catholic School and its employees from all liability relating to the administration of non-prescription and/or prescription medication to my (our) child.

_____ _____

Parent/Guardian Signature Date

Date/Time	Medication/Dosage	Reason Given	Admin. By