St. Joseph Catholic School

Authorization for Administration of Non-Prescription Medication at School

Student Name ____ Grade _____ DOB ___________

I (we) as parent/guardian, authorize that the above-named student be administered/provided the following non-prescription medication(s) by St. Joseph Catholic School personnel. Dosage instructions from the bottle/container will be followed unless otherwise specified by parent/guardian.

Please check the following medication(s) to be administered as needed:

1. Ibuprofen (Motrin, Advil): _____
2. Tylenol (Acetaminophen): _____
3. Benadryl (will contact parent/guardian prior to giving): _____
4. Tums: _____

Other medication my child may take (please give complete instructions): ______________________

____

Note: St. Joseph Catholic School will keep in stock above medications. Over the counter medications not listed above are not provided by the school.

Start Date: ___________________________________ End Date: ________________________________

I (we) as parent/guardian, understand that all medications will be turned into and stored in the office. I (we) understand that monitoring the side effects and possible adverse reactions of the medication remains my (our) responsibility. Therefore I (we) release St. Joseph Catholic School and its employees from all liability relating to the administering of the medication to the above-named student. I (we) give permission to share pertinent medical information with appropriate school personnel.

____ _________________ ______________________

Parent/Guardian Signature Date Phone #

Please Note:

Medication must be sent to the school in its original container and be kept in the school office.

Date	Time	Medication/Dosage/Route	Reason	Admin By