
# AUTHORIZATION *for* NONPRESCRIPTION MEDICATION *or* TREATMENT

Parent(s) or Guardian(s):

The following information is necessary for any student to use nonprescription medications in school or on school trips. All spaces must be completed.

Student Name _____ Date of Birth _____

Address _____ Grade/Teacher _____

I am requesting permission for my child named above to have the following over-the-counter medication(s) administered by a Designated Employee:

_____
Medication(s) with Dosage(s)

_____
Special Instructions

A. I will assume responsibility for safe delivery of the medication to the school in its original container.
B. I will notify the school immediately if there is any change in the use of the medication or treatment.
C. Our physician has instructed that this medication should be administered at the above dosage.
D. I release and agree to hold Saint Mary School, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from the authorization.
E. I will call the school office and send a written note if my child is taken off this medication. I will retrieve the medication within three (3) days. I understand the medication may be disposed of after three days.

Parent/Guardian signature _____ Date _____ Phone number _____