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

66 E. William Street Delaware, Ohio 43015 Phone: 740.362.8961 Fax: 740.362.3733