St. John School

PARENT REQUEST and AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION

Student's Name: _____

Birthdate: _____ Grade: _____

Name of Over-the-Counter Medication: _____

Reason for Medication: _____

Dosage of Medication (not to exceed written label directions without a physician's orders):

_____

When It Should Be Given: _____

Start Date: _____ Stop Date: _____

Is this a scheduled medication or an as needed medication? _____

Considerations/Side Effects: _____

Guidelines:

1. Over-the-Counter medication must be in its original container.
2. I will notify St. John School immediately if there is a change in the use of the above non-prescription.
3. I release and agree to hold harmless St. John School, its employees, officers, and staff from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____

Phone Number: _____

Date: _____