ST. JOSEPH'S
CATHOLIC SCHOOL
"The Gift That Lasts a Lifetime"

# Medication Administration Authorization- OTC- (Over the Counter Medications)

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|---|---|---|---|
| **Student's Name** | | **DOB** | **Grade** |
| **Parent/Guardian** | | **Teacher/Grade** | |
| **Parent/Guardian Phone Numbers:** | **Home:** | **Work:** | **Cell:** |
| **Physician/Phone:** | | **Hospital/Phone:** | |

**FOR ANY OVER-THE-COUNTER MEDICATION THAT WILL BE ADMINISTERED BY SCHOOL STAFF ACCORDING TO PACKAGE DIRECTIONS.**

**Drug Allergies:** _____

OVER-THE-COUNTER MEDICATION
Name of Medication/Treatment _____
Dose _____
Comments _____

OVER-THE-COUNTER MEDICATION
Name of Medication/Treatment _____
Dose _____
Comments _____

**FOR ANY OVER-THE-COUNTER MEDICATION THAT STUDENT WILL SELF CARRY ACCORDING TO PACKAGE DIRECTIONS.**

OVER-THE-COUNTER MEDICATION
Name of Medication/Treatment _____
Dose _____
Comments _____

PARENT CONSENT I authorize my child to receive the above listed medication while at school and relieve St. Joseph's School and personnel of all responsibility. I authorize the School Nurse and/or the designated medication provider to provide the medication to my child. I acknowledge that I have read, understand, and agree to comply with the school's medication policy. I certify that the information included on this form is accurate to the best of my knowledge. I certify that the medications I have authorized the school to provide to my child do not, to my knowledge, interact, and I certify that my child is not known to be allergic to them. I understand and hereby release St. Joseph's School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

_____ _____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian Date