

## Authorization to Administer Over-The-Counter Medication

**Subject to the Release and Indemnification terms below**, by my/our signature below, I/we consent to the School's administration of the Over-the-Counter (nonprescription) ("OTC") medication listed below.

<b>Student Name:</b>		
<b>School Name:</b>		
<b>Medication</b>	<b>Dosage</b>	<b>Duration of request</b> ___/___/___ to ___/___/___
<b>Directions</b>		
<b>Indication (reason) for medication:</b>		
<b>Physician's Name</b>	<b>Address</b>	<b>Phone Number</b>

I/we understand and agree to the following (please initial each item below):

\_\_\_\_\_ I/we have consulted Student's primary healthcare provider and have determined that the administration of the OTC medication described in this section is advisable and safe.

\_\_\_\_\_ I/we understand I/we are responsible for providing the medications in the manufacturer's original packaging. I/we also understand that the OTC medication I/we provide must have the manufacturer's label identifying the medication, its ingredients, dosing recommendations, possible drug interactions and/or warnings. In addition, the student's name must be printed on the container.

\_\_\_\_\_ I/we understand any instructions to administer an OTC medication in a manner inconsistent with the manufacturer's recommended instructions must be ordered by a physician. A copy of the physician's prescription/instructions will be required prior to administration.

\_\_\_\_\_ I/we hereby give my permission for the School to give the OTC medication to my child according to the directions stated above.

\_\_\_\_\_ I/we give my permission to the School to contact the student's physician to report any adverse reactions or side effects.

\_\_\_\_\_ **I/we further agree to release and hold the School, The Roman Catholic Diocese of Dallas, and their respective employees, officers, contractors, and/or agents harmless from and against any and all claims arising from the administration of this medication by the School.**

\_\_\_\_\_ I/we take full responsibility for any adverse effects of such medication administration.

\_\_\_\_\_ I/we agree to notify the School in writing of the termination of this request or when any change in the above orders are necessary. I/we further understand that this consent is only valid for the specific medication listed above for the duration listed above.

**Parent Signature:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Daytime Telephone:** \_\_\_\_\_

**Daytime Telephone:** \_\_\_\_\_