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. ***Only one medication per form.***

Student Name:		
Grade	**Dosage**	**Duration of request** __/__/__ **to** __/__/__
Medication	**Route of administration**	**Time to be given**
Indication and directions for medication:		
Physician's Name	**Address**	**Phone Number**

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 am/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/ our permission for the school to give the OTC medication to my/our child according to the directions stated above.

____ I/we give my/ our permission to the school to contact the student's physician to report any adverse reactions or side effects.

_____ **I/we further agree to release, indemnify, 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.

____ I/we understand medication may be administered by non-medical personnel.

Parent/Guardian Signature	Date
Parent/Guardian Name	
Physician Signature (stamped signature not accepted}	Date
Physician's Name	Phone Number