

## Authorization to Administer Over the Counter Medication

Student \_\_\_\_\_ Grade \_\_\_\_\_

<b>Medication 1</b>	<b>Dosage</b>	<b>Reason</b>	<b>Number of Days</b>
<b>Instructions</b>			
<b>Possible Side Effects:</b>			
<b>Medication 2</b>	<b>Dosage</b>	<b>Reason</b>	<b>Number of Days</b>
<b>Instructions</b>			
<b>Possible Side Effects:</b>			

*The above medication is to be administered during the school day in accordance with above instructions. I agree to accept communication about the student and/or medication and understand the non-medical, trained school personnel may administer the medication.*

*School office staff, designated teachers, or school principal will administer medication. I agree to hold St. Charles School/Parish, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.*

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Authorization to Administer Prescription Medication

Student \_\_\_\_\_ Grade \_\_\_\_\_

<b>Medication 1</b>	<b>Dosage</b>	<b>Reason</b>	<b>Number of Days</b>
<b>Instructions</b>			
<b>Possible Side Effects:</b>			
<b>Medication 2</b>	<b>Dosage</b>	<b>Reason</b>	<b>Number of Days</b>
<b>Instructions</b>			
<b>Possible Side Effects:</b>			

*The above medication is to be administered during the school day in accordance with above instructions. I agree to accept communication about the student and/or medication and understand the non-medical, trained school personnel may administer the medication.*

*School office staff, designated teachers, or school principal will administer medication. I agree to hold St. Charles School/Parish, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.*

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_