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**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.

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| **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.

 Turn over ----

 **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.

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| **Parent/Guardian Signature** | **Date** |
| **Parent/Guardian Name** |
| **Physician Signature (stamped signature not accepted)** | **Date** |
| **Physician’s Name** | **Phone Number** |