ST. IGNATIUS

Authorization for the Administration of
Over The Counter Medications at School (Optional)

2019-2020 School Year

Student Name _____ Date of Birth _____

Grade_____ Homeroom_____

As this student's parent, I give permission for my child to receive the following Over The Counter (OTC) medications during the school day as needed for comfort measures.

- I understand that only the OTC medications on this form will be administered as needed according to my child's age/weight as stated on the OTC label.
- I understand that if my child is prescribed a dosage outside standard dosing, I will provide an Administration of Medication form signed by my pediatrician along with the medication.
- I understand that a reasonable attempt to reach me will be made prior to administering OTC medication.
- I agree that if my child needs frequent OTC medications, I will provide that medication for my child upon request.
- I agree to hold harmless the staff of St. Ignatius from all claims as a result of any and all acts performed under this authority.
- I will inform the school if there is a change in any of this information.

Circle Yes or No for consent for each medication listed.

Acetaminophen (Tylenol) for headache, or minor pain	Yes	No
Ibuprofen for headache, menstrual cramps, minor pain	Yes	No
Cough drops for sore throat	Yes	No
Anti-itch lotion or cream	Yes	No

Is student allergic to any medications? ☐ No ☐ Yes, allergic to _____

_____ _____

Parent Signature Date

_____

Parent Printed Name

How can we reach you during school hours?

_____ _____ _____

Home Phone Work Phone Cell Phone

Rev 7/2020