Saint Teresa Catholic School
Authorization for Administration of Non-Prescription Medication
2024-2025

Student Name: _____ Grade: _____

Parent/Guardian: _____ Daytime Phone # _____

I (We) as parent/guardian of the above named student authorize the personnel of Saint Teresa School to give my child the following **non-prescription medication** should it be necessary on an occasional basis. Dosage instructions from the bottle/container will be followed per child's weight, unless otherwise specified by parent. If the medication is needed on a regular basis, please provide the student with their own supply. If a child is given medication while at school, an email will be sent home informing Parent/Guardian of what was given, how much, and the time it was given.

Please indicate the following that apply:

1. Children's Ibuprofen (Motrin, Advil) _____
2. Ibuprofen 200mg _____
3. Children's Tylenol (Acetaminophen) _____
4. Tylenol 500mg _____
5. Cough Drops _____
6. Tums_____
7. Topical ointment (Neosporin, triple antibiotic ointment, hydrocortisone) _____

Other medication my child may take with **complete instructions** (examples: decongestants, cough medicine, antacids). These medications would need to be provided and **the child would have to follow the illness policy before these medications would be considered.**

Name of Medication(s): _____

Medical Management Plan? Yes No
(Required for asthmatic, anaphylactic and diabetic medications).

I (We) understand that if this form is not signed and returned to the school office, my child will not be given any medication at school. I (We) understand that all medications will be turned in to and stored in the office, unless a Medical Management Plan has been completed granting my (our) student permission to carry emergency medications on their person. I (We) accept ultimate responsibility for monitoring the effects and possible adverse reactions of these medications on my (our) child. I (We) therefore release Saint Teresa School and its employees from all liability relating to the administration of non-prescription and/or prescription medication to my (our) child.

Special Instructions:

Parent/Guardian Signature_____ Date _____

Date Time	Medication/Dosage	Reason Given	Admin. By

10/2/23