SAINT ANDREW
SCHOOL

AUTHORIZATION *for* NONPRESCRIPTION MEDICATION *or* TREATMENT

To the Parent:

The following information is necessary for any student to use nonprescription medications in school. All spaces must be completed.

Student Name _____ Address _____

Teacher / Grade _____

A. I am requesting permission for my child named above to have the following over-the-counter medication(s) administered by a Designated Employee:

Medication _____

Dosage _____

B. I will assume responsibility for safe delivery of the medication to school in its original container.

C. I will notify the school immediately if there is any change in the use of the medication or treatment.

D. Our physician has instructed that this medication should be administered in the above dosage.

E. I release and agree to hold Saint Andrew School, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from the authorization.

F. I will call the school office and send a written note if my child is taken off this medication. I will retrieve the medication within three (3) days. I understand the medication may be disposed of after three days.

Parent / Guardian signature _____ Date _____

Home phone _____ Mobile Phone _____

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