

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the parent:

I request that my child, _____ Grade _____ H.R. _____ be assisted in taking the over-the-counter medications described below at school by authorized persons. I understand that I am responsible for submitting the medication in a proper and timely manner, and that, if necessary, the school may request additional information from the physician regarding this medication. I agree to abide by the Medication Regulations that accompanied this form, and I understand that this form must be renewed annually and anytime there is a change in drug, time administered or dosage.

I agree to waive the School, their officers, representatives and employees from any and all liability, claims, demands, and causes of action arising out of or in any way connected with the giving of the prescribed medication or treatment. The undersigned parent or guardian hereby assumes all risk of injury or damage to the minor child receiving prescribed medication or treatment during school activities, and specifically waives any claim for acts of negligence by employees of the School.

Furthermore, as parent or guardian of the minor child to receive over-the-counter medication and/or treatment, the undersigned hereby expressly agrees to indemnify and forever hold harmless the Catholic Schools Office/Diocese of Erie/Sisters of Mercy, officers, and their employees against loss or any claims, demands, causes of action that might be brought by the minor incurred by the taking of the over-the-counter medication and/or treatment given by the School during regularly scheduled school hours or activities. As parent or guardian, I hereby waive all exemption rights under all state laws against any claims for reimbursements of indemnification.

_____ Date _____ Parent/Guardian Signature _____ Daytime Phone _____

The following section is to be completed by the parent:

Name of over-the-counter medication(s) _____

Reason for which medication is given _____

Dosage _____ Frequency _____

Other information _____

From _____ to _____
(dates medication to be given)

Note: Any alterations to the printed portion of this form will render it null and void.