# AUTHORIZATION FOR
# PRESCRIPTION AND 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 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 prescribed medication and/or treatment, the undersigned hereby expressly agrees to indemnity 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 prescribed 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 physician:**

Diagnosis for which medication is given _____

Name of medication(s) _____

Dosage _____ Time _____

Can this time be adjusted to accommodate class schedules? _____

If so, by how much _____

If medication is to be given as needed, describe indications and intervals _____

_____

List significant side effects _____

_____

Other information _____

_____

From _____to _____ _____

(dates medication to be given) Physician Signature

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