

THIS FORM IS REQUIRED FOR ALL 6-8 GRADE STUDENTS

Form must be returned to the school office by Friday, July 28, 2017.

The form may also be scanned into the new Health Portal!!

Parent/Doctor Consent for Over the Counter Medication Administration at St. Aloysius Catholic School

Student Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Grade: _____

Home Phone: _____ Cell/Work Phone: _____

Please list any allergies: _____

List all medications student takes at home: _____

I **DO NOT** grant permission for SAS to administer medicine to my child.

Parent Signature _____

No Need To Proceed Any Further

I **DO** grant permission for SAS to administer medicine to my child.

Parent Signature _____

If you do give permission to SAS to administer medication to your child, please respond to the following questions:

1. Do you give the SAS nurse permission to share information about your child, relative to medication administration with teachers or other SAS staff. Yes ___ No ___
2. Do you understand that medication will be destroyed if not picked up within one week following the end of the school year, or when medication has expired? Yes ___ No ___
3. Any medications you would like to be administered at SAS must first be administered at home to observe your child for adverse reactions before they can be administered at SAS. Yes ___ No ___
4. Have you administered the initial dose at home and observed your child for 24 hours for an adverse reaction? Yes ___ No ___
5. Do you consent for a teacher or other SAS staff to administer medication(s) on a field trip? Yes ___ No ___

Please initial below by the drugs you grant SAS permission to administer to your child.

Only initial those that you desire to be administered, dosage per label instructions

_____ Advil (ibuprofen)

_____ Benadryl-for severe allergic reactions

_____ Tylenol (acetaminophen)

_____ Cough drops

IN ORDER FOR SAS TO ADMINISTER MEDICATION TO YOUR CHILD, THIS FORM MUST BE SIGNED BY YOUR CHILD'S PHYSICIAN

Physician Signature: _____ Date: _____

(OVER)

I/We, _____ by my signature below, individually and behalf of our above named child, agree, to the maximum extent allowed by law, to indemnify, defend (including attorney's fees) and hold SAS and its faculty, staff, volunteers, and any representatives or persons acting for SAS harmless of and from, and release same from, any liability, claims, and/or causes of action of any type, for any losses, damages, and/or injuries sustained by the above named child, and or by us or anyone who may recover under any such claims or for any such loses or damages in connection with my child's self-administration of emergency medications, whether during on or off-campus activities, academic activities, athletic or other extracurricular activities, field trips, and/or travel. I also understand, acknowledge, and accept the inherent danger associated with my child's self-administration of emergency medication and waive any claims to hold SAS and its faculty, staff, volunteers, and any representatives or persons acting for SAS responsible for same. This indemnity, hold harmless and release agreement specifically applies to such inherently dangerous activities.

Furthermore, SAS and its faculty, staff, volunteers, and any representatives or persons acting for SAS shall have no liability or responsibility for over the counter medications that are defective, either by their design or dosage recommendations or that are misused by the student. The misuse of medications will result in the student's loss of medication privileges.

Parent/Guardian Signature: _____ Date: _____