THIS FORM IS REQUIRED FOR ALL 6-8 GRADE STUDENTS

DUE JULY 15, 2016

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 to be given at school:_____
List all medications student takes at home:_____

Please respond to the following questions:

1. Do you give permission for the SAS nurse to share with teacher or other SAS staff information about your child relative to medication administration, as the nurse deems necessary? 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. Do you understand that you must administer the initial dose at home and observe your child for an adverse reaction for 24 hours after administering the dose before the medication can or will 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_____

If you do not want SAS to administer OTC medications to your child, please initial the "Administer no Medication" Statement below:

ADMINISTER NO MEDICATION_____

If you want SAS to administer OTC medications to your child, please complete and sign the statements below:
I hereby grant by my initials permission for the teacher, and nurse to administer the following OTC medications:

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

_____Advil (ibuprofen) _____Benadryl-for severe allergic reactions
_____Tylenol (acetaminophen) _____Cough drops
List any other OTC medications that you may wish to be provided: (**Must bring to school)_____**

Parent/Guardian Signature:_____Date:_____

Physician Signature:_____Date:_____

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:_____

This authorization shall remain effective until the end of the 2016-2017 school year.