St. Louis Catholic School
17 St. Louis Place • Batesville, IN 47006

Parent Permission for Administration of Medication to Student(s) For Over-the-Counter Medication

Student Name: _____Birth Date:_____

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Name of Medication: _____

Type of Medication: _____(i.e. Tablet, Capsule, Liquid, Inhaler)

Reason for Medication:_____

Instructions (Time and dose to be given at school):_____

_____

Start Date: _____ Stop Date:_____

Restrictions and/or important side effects if any: _____

_____

I give permission to school personnel to administer the above medication as instructed and agree to deliver the medication to the school in the original container with original prescription label intact.

I will notify the school immediately of any change in physician or change or discontinuation of the medication above.

I understand that school personnel cannot administer prescription drugs in amounts, which exceed the recommended dose in the PHYSICIANS DESK REFERENCE (PDR). I understand that it is the student's responsibility to report on time to the office for this medication. I agree to hold employees, St Louis School and the Archdiocese of Indianapolis free from all responsibility for results of such medication.

Parent/Guardian Signature: _____Date:_____

Home Phone: _____Work:_____Cell:_____