

CLEVELAND CENTRAL CATHOLIC HIGH SCHOOL

**AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION**

1. This form must be completed in order for your student to take any over the counter medication at school. (e.g. Advil, Motrin, Tylenol, Midol, etc.)
2. You must provide the medication, in its original container, to the school clinic. It will be locked in the medicine cabinet and then administered to your student when they need it. (headache, cramps, etc)
3. Medications **MAY NOT** be kept in lockers, purses, pockets, book bags, etc. **ALL MEDICATION IS TO BE STORED AND LOCKED IN THE CLINIC.**
4. Multiple medications may be listed **BUT** the proper medication bottle **MUST** accompany each one.

STUDENT NAME \_\_\_\_\_ GRADE \_\_\_\_\_

ADDRESS \_\_\_\_\_

- Medication name \_\_\_\_\_
- Dose of medication \_\_\_\_\_
- Time or interval to be used \_\_\_\_\_
- Begin date \_\_\_\_\_ End date \_\_\_\_\_

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- Dose of medication \_\_\_\_\_
- Time or interval to be used \_\_\_\_\_
- Begin date \_\_\_\_\_ End date \_\_\_\_\_

Physician printed name \_\_\_\_\_ Physician signed name \_\_\_\_\_

PLEASE REGARD MY SIGNATURE BELOW AS MY ASSURANCE THAT I RELEASE CLEVELAND CENTRAL CATHOLIC HIGH SCHOOL AND ANY OR ALL OF THE SCHOOL'S OFFICERS OR EMPLOYEES FROM ANY LIABILITY OR DAMAGES RESULTING FROM THE CONSEQUENCES OR ADVERSE REACTIONS OF OUR CHILD'S TAKING OR FAILING TO TAKE THIS MEDICATION AT THE TIMES PRESCRIBED.

Mom/guardian PRINTED name \_\_\_\_\_ Cell/Emerg PH \_\_\_\_\_

Dad/guardian PRINTED name \_\_\_\_\_ Cell/Emerg PH \_\_\_\_\_

Mom signature \_\_\_\_\_

Dad signature \_\_\_\_\_