Office of Catholic Schools
excellence by design

DIOCESE OF ARLINGTON

High School OTC Medication Authorization

Release and indemnification agreement

PART I TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request designated school personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use medication, provided the designated school personnel comply with the provision of part II below.

THIS FORM IS TO BE USED FOR CLINIC STOCKED OVER-THE-COUNTER (OTC) MEDICATIONS ONLY.

Student Name (Last, First, Middle Initial)	Date of Birth

Drug Allergies	School	School Year

PART II TO BE COMPLETED BY PARENT OR GUARDIAN FOR OCCASIONAL USE OF CLINIC STOCKED (OTC) MEDICATION (LICENSED HEALTH CARE PROVIDER MUST COMPLETE AND SIGN FOR OTC'S ADMINISTERED FOR 4 OR MORE CONSECUTIVE DAYS.)

Occasionally, your child may unexpectedly need medicine during a school day. For those occasions, the school clinic stocks a limited number of over the counter medications which the school nurse may administer with your written permission. The school nurse will assess your child and pertinent comfort measures may be utilized before medication is administered. Only the school nurse or her licensed designee may administer the OTC medications, based on nursing judgment and as instructed on the medication label.

The school nurse has my permission to administer the following nonprescription medications:

Ibuprofen 2 (200mg) tablets to reduce inflammation/fever *	☐ Yes	☐ No
Acetaminophen 2 (325 mg) tablets to reduce pain/fever **	☐ Yes	☐ No
TUMS (antacid) for minor upset stomach	☐ Yes	☐ No
Cough drops (cherry flavored/menthol drops)	☐ Yes	☐ No

Parent Signature _____ Daytime phone _____ Date _____

You must fill out and sign a new form at the beginning of each school year.
Any questions, please contact the school nurse directly.

PART III TO BE COMPLETED BY PRINCIPAL, REGISTERED NURSE, LICENSED NURSE OR HEALTH AID

☐ Parts I and II above are completed including signatures.

Signature _____ Date _____

No LPN or clinic room aide shall administer medication or treatment, unless the principal has reviewed all the required clearances.

* Ibuprofen is equivalent to Motrin/Advil
** Acetaminophen is equivalent to Tylenol

2008