NORWALK CATHOLIC

93 East Main Street
Norwalk, Ohio 44857
419.668.7223

PARENT AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

Student Name_____ Date of Birth_____ Grade_____

Allergies_____

Name of medication and dosage_____

Special Instructions/Directions for use_____

Medication Expiration Date_____ Date When No Longer Needed_____

Name of Physician_____ Telephone #_____

I authorize school personnel to follow the above medical instructions. **I will provide the above medication for my child and deliver the medication to the school.** The medication must be in the original container. I will notify the school if I change physicians or if the medication or the dosage is changed or eliminated.

I understand that school personnel are performing a service that is my responsibility. I release all school personnel of any liability related to performing this service, whenever reasonable precautions have been observed.

Over-the-counter medication will be sent home with my student unless I contact the office to make other arrangements.

Signature of Parent/Guardian_____ Date_____

Parent/Guardian name (printed)_____ Phone #_____

(Office Use Only)

Signature of school personnel receiving medication_____

Date received_____