STUDENT NAME: _____ **Allergies:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Over the Counter and As Needed Medications

We will have on hand and as need and will keep the following over the counter medications in the infirmary. You do not need to bring any of these OTC meds.

PARENTS/GUARDIANS:
Please initial the shaded box next to each medication you approve.
These CANNOT be administered to your child WITHOUT YOUR CONSENT.

Staff: Please record date, time, dosage and initials whenever a medication is given, then initial and sign your name at the bottom.

Over the Counter Medications	Parent Initials	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial	Date / Time	Dose / Initial
Motrin *(child or adult dose)*											
Tylenol *(child, junior or adult dose)*											
CLARITIN											
Benadryl											
Cough Drops/Throat lozenge											
Pepto Bismol/Tums											

RELEASE FOR DISPENSING OF PRESCRIPTION MEDICATION

We, the undersigned parent and/or guardian of:

_____ _____ Born _____/____/_____

(Student's Name) (Grade) Mo Day Yr

do hereby sign and execute this release on behalf of us and on behalf of our minor son/daughter/ward.

NAME OF MEDICATION:_____

DOSE:_____

TIME TO BE GIVEN:_____

DURATION:_____

ATTACH DOCTOR'S NOTE REGARDING EMERGENCY CARE PLAN AND ADMINISTRATION OF MEDICATION.

☐ Check here, if this release is for a metered dose asthma inhaler, insulin pump or epinephrine auto-injector, which the student will possess and use at his/her own discretion in school or at school activities. The physician and parents/guardian signature below apply to the inhaler, insulin pump or epinephrine auto-injector possession and use by students as permitted in Public Act 10 – Revised School Code.

_____ _____ _____

(Doctor's Signature) (Please Print Name) (Date)

___(_____)_____

(Phone Number)

We hereby waive any liability whatever to the school or the Archdiocese of Detroit or any of its personnel, that might occur as the result of giving said medication in the indicated dosage at the time requested to our minor son/daughter/ward.

PARENT/GUARDIAN _____

(Signature)

_____

(Print Name)

DATE _____