DIOCESE OF LINCOLN CATHOLIC SCHOOLS
OVER-THE-COUNTER (OTC) MEDICATION AUTHORIZATION FORM

Medication not listed in Power School

School Year: 20__ -20 ____

Student Name_____ **Grade** _____

Parent/Guardian _____ **Daytime Phone #** _____

If **over-the-counter medication** is needed on a regular basis:

- It is the parent/guardian's responsibility to supply any OTC medication required by their child;
- The OTC medication will be administered in accordance with manufacturer labeling unless otherwise directed in writing by a licensed healthcare provider. School personnel may decline to administer OTC medication if dosage instructions are unclear or if administration appears unsafe;
- All medications provided by the parent/guardian must be in the original manufacturer's container with the labeling intact and must not be expired;
- School personnel may notify parent/guardian regarding OTC medication administered;
- Parent/guardian is responsible for notifying the school in writing of any allergies related to OTC medications;

Name of OTC medication(s):_____

Your written consent is **required** prior to school personnel providing or administering OTC medication to your child at school. By signing below, you agree to the following:

- I acknowledge and agree to the terms in this Authorization From and understand my child will not be provided OTC medication by school personnel unless this form is signed.
- I accept ultimate responsibility for monitoring the effects and possible adverse reactions of these medications on my child.
- I acknowledge the risks associated with administering OTC medication and authorize school personnel to administer the medication(s) identified in this form in accordance with school policy. I agree to hold harmless and indemnify the school and its employees for claims arising out of administration consistent with this authorization, except for claims arising from willful misconduct or gross negligence.

_____ _____
parent/guardian signature date

FOR SCHOOL USE ONLY

Date Received: __ _____ **Received By**: _____
Medication Received: Yes / No **Expiration Date Checked**: Yes / No