

# NON-PRESCRIPTION Medication Permission Form

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## *Notice to Parents of Students Who Require Administration of Non-Prescription Medication*

Students requiring non-prescription (over-the-counter) medication, such as aspirin or cold medicine, must bring the medication **in its original container** along with this completed Non-Prescription Medication Permission Form signed by a legal parent or guardian to the school office. No medications of any type should be stored in lockers, classrooms, or with the student.

Columbus Catholic Schools' office personnel will administer medications. No medications will be given to students unless the items listed below are completed. Students are responsible for coming to the office to receive medication at the designated time. If a student refuses to take the medication indicated below, the parent/guardian will be notified immediately.

If you have any questions regarding medication administration procedures, please contact your school office.

### ***Parent Permission Form*** *(This section is to be completed by the parents.)*

Student's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Names \_\_\_\_\_

I hereby authorize Columbus Catholic Schools' designated staff to administer medication to my son/daughter as indicated below. I will notify the school in writing if there are any changes to the medication. A new form is necessary if there is a change in dosage. I further agree that I will not hold designated school personnel responsible for any claims arising from the administration of medication at Columbus Catholic Schools.

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In order for Columbus Catholic Schools to accurately distribute prescribed medication, please complete the following information.

<b>Medication</b>	<b>Dose</b>	<b>Time to be given</b>	<b>Duration (entire school year, 10 days, etc.)</b>

Any side effects or concerns: \_\_\_\_\_

**End of Year medication instructions (please check one):**

\_\_\_\_\_ I will pick up the medication on the last day of school.

\_\_\_\_\_ Please send the medication home with my child on the last day of school.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_