Huron-Superior Catholic
DISTRICT SCHOOL BOARD

AUTHORIZATION FOR THE ADMINISTRATION OF NON-PRESCRIPTION MEDICATION

NAME OF STUDENT_____ **BIRTHDATE**_____

ADDRESS_____ **TELEPHONE**_____

SCHOOL_____ **GRADE**_____ **TEACHER**_____

PART I - PARENTS' STATEMENT

1. **Name/type of medication:** _____
2. **Dosage/amount to be given:** _____
3. **Frequency/times to be administered:** _____
4. **Dates for Authorization (Day/Month/Year)** _____
   (Start - D/M/Y) **(End - D/M/Y)**
5. **Storage/Safekeeping requirements:** _____

PART II - PARENT(S)/GUARDIAN(S) REQUEST, APPROVAL, AND WAIVER

I hereby release and hold harmless the Huron-Superior Catholic District School Board and its employees from any liability arising as a consequence of the administration of the NON-PRESCRIBED medication in the manner prescribed.

I hereby request and give my permission for the above-named school to administer the medication on this form to my child.

_____ _____

Parent's/Guardian's Signature **Date**

PART III - DESIGNATED PERSON(S) ADMINISTERING NON-PRESCRIBED MEDICATION

I have agreed to administer the NON-PRESCRIBED medication as requested by the parents/guardians and in accordance with their directions listed above.

_____ _____

Signature of Person(s) Administering Medication **Date**