ST. ANDREW
ST. ELIZABETH ANN SETON
CATHOLIC SCHOOL

5900 Buckwheat Road
Milford, OH 45150
513-575-0093
saseasschool.org

NON-PRESCIPTION MEDICATION AUTHORIZATION School Year _____-_____

STUDENT INFORMATION

Student's Name: _____ **Grade:** _____
Date of Birth: ____/_____/_____ **Age:** _____
Drug Allergies: _____ **Weight:** _____**pounds**

Medication Name: _____ **Dosage:** _____

Frequency/Times to Be Given: _____ **Route:** _____

Start Date: _____/_____/_____ **Stop Date:** _____/_____/_____

A non-prescription medication cannot be given for more than 10 doses/10 days without a healthcare provider's statement.

Reason for Taking Medication: _____

Potential Side Effects: _____

Special Instructions for administration: _____

Special Instructions for storage: _____

Printed Name of Healthcare Provider: _____

Health Provider Phone Number: (_____)-_____-_____

PARENT AUTHORIZATION

I authorize St. Andrew-St. Elizabeth Ann Seton School or its authorized representative to administer the above non-prescription medication to my child named above in accordance with my instructions above and agree to:

1. **Submit this request to school nurse or authorized school personnel.**
2. **Provide the medication in the original container.**
3. **Submit a revised non-prescription medication authorization form if any of the above information changes.**
4. **Release St. Andrew-St. Elizabeth Ann Seton School and their designated representative from any liability concerning the administration of the medication to the student.**

Parent/Guardian Name: _____**Phone: (____)____-____**
Parent/Guardian Signature: _____ **Date:** _____/_____/_____