Marian Central Catholic High School 2023-2024

Medication Authorization Form

It is our policy that (Rx) prescription and (OTC) over-the-counter medication should be administered in the home when at all possible. However, under certain circumstances, it is in the best interest of the student to take prescribed or OTC medication during the school day. In the case of the student needing a prescription medication during the school day, the doctor and the parent/guardian must provide authorization to the school office. In the case of the student needing an over-the-counter medication during the school day, the parent/guardian must provide authorization to the school office. The medication must be brought to the school office in the original container that includes all prescription or OTC information including the student's name. The parent/guardian must assume responsibility for informing the school in writing of any change in the student's health or change in medication. The prescribed or OTC medication will be kept in the school office, and the student is responsible for coming to the school office to take the medication. A Medication Log will be kept in the office where each student must sign every time a medication stored in the office is taken. **A student may carry on his or her person and may self-administer an epinephrine auto-injector or asthma inhaler where the student or student's parent/guardian supplied the epi-pen or asthma inhaler and presented the school with a prescription authorizing the student to use the epi pen or inhaler.** This Authorization is valid for the dates indicated or the end of the current school year. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Student: _____ Date of Birth: _____

Address: _____

Over the Counter Medication Authorization

Medication: _____

Dose: _____Time of Administration at School: _____

I hereby state that the information is above is accurate and give permission to Marian Central Catholic High School personnel to administer the medication identified to the above-named student.

Parent/Guardian Signature: _____ Date: _____

Phone Number: _____

Prescription Medication Authorization

Medication: _____

Dose: _____Time of Administration at School: _____

Duration (from date): _____to (date): _____

Reason for medication prescribed: _____

Possible Side Effects: _____

Physician's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____