SAINT XAVIER HIGH SCHOOL
MEDICATION AUTHORIZATION FORM 2026-2027

STUDENT NAME:_____ STUDENT I.D. #_____
Last First Middle

Please allow my son to take the following medication(s):

Medication	Purpose	Dosage	Circumstances under which medication must be administered	Frequency of Administration	Quantity

All prescription medications to be taken during the school day should be brought to Student Services accompanied by this form. The medicine must be in the original container with the student's and the doctor's names on the bottle.

Over the counter medications (*this includes any seasonal allergy medication or cough drops*) should also be accompanied by the medication form. It must be in the original container with the student's name written on the package. All medications are kept in the nurse's office. Students may not carry any medication on them with the exception of asthma or diabetes medication or an Epi Pen as long as the signed parent/doctor form has been turned in. This is available at saintx.com/forms.

I agree to indemnify, hold harmless, waive and relinquish any and all claims for any injuries my son may have against Saint Xavier High School and its officers, agents, employees, representatives or volunteers arising out of, or in connection with, the distribution of my son's medication as directed by his doctor's or my instruction.

_____ _____
Parent/Guardian Signature **Date**

For office use:

_____ _____
Administered by Date