



PRESCRIPTION MEDICATION AUTHORIZATION FORM

This form must be completed and signed by the student's parent before any medication can be dispensed. Please note: under no circumstances may a student keep prescription or over-the-counter medication on his person or in his locker during the school day.

Student's Name _____ Grade _____
Parent/Guardian's Name _____ Preferred Phone Number in Case of Emergency _____
Emergency Contact's Name _____ Phone Number _____

Name of medication and dosage _____ Time(s) to be administered _____ If medication is to be given only as needed, please describe symptoms _____ _____ Discontinuation Date (if applicable) _____	Name of medication and dosage _____ Time(s) to be administered _____ If medication is to be given only as needed, please describe symptoms _____ _____ Discontinuation Date (if applicable) _____
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Medication should be given at home whenever possible. If medication must be given at school, parents must sign this authorization form and send the medication in its original, pharmacy-labeled container. Over-the-counter medication must be sent in its original, unopened packaging. All medications are stored in a temperature controlled, secure location.

I understand my child will be assisted in taking the medication(s) listed above by the school nurse or authorized CBHS personnel. I agree to release, indemnify, and hold harmless CBHS and its employees or representatives from any claim, liability, or expense arising from giving or failing to give the prescribed medication, including claims based on alleged negligence by CBHS or its employees. I am responsible for notifying the school in writing of any change in medication or its administration.

Parent/Guardian's Signature _____ Date _____



OVER-THE-COUNTER MEDICATION AUTHORIZATION FORM

This form must be completed and signed by the student's parent before any medication can be dispensed. Please note: under no circumstances may a student keep prescription or over-the-counter medication on his person or in his locker during the school day.

In the event my son(s), STUDENT NAME(S), need(s) a pain reliever or other minor over-the-counter treatment for a headache, earache, allergy symptoms, cough, cold, or minor skin irritation, I authorize Christian Brothers High School staff to give him one of the following medications, with or without a phone call beforehand, according to my choice below:

- | | | |
|---|--|--|
| ☐ Advil/Motrin (Ibuprofen) | ☐ Mylanta | ☐ Antihistamine cream |
| ☐ Tylenol (Acetaminophen) | ☐ Claritin (Loratadine) | ☐ Cough syrup/cough drops |
| ☐ Aleve (Naproxen) | ☐ Benadryl | ☐ Antibiotic ointment |
| ☐ Antacid | ☐ Visine/Allergy Drops | ☐ Hydrocortisone cream |

If my son needs any of these medications frequently, I will provide the school with a labeled bottle of the medication he uses.

Please check your choice:

- ☐ YES ☐ YES, but with phone call beforehand ☐ NO

Medication should be given at home whenever possible. If medication must be given at school, parents must sign this authorization form and send the medication in its original, pharmacy-labeled container. Over-the-counter medication must be sent in its original, unopened packaging. All medications are stored in a temperature controlled, secure location.

I understand my child will be assisted in taking the medication(s) listed above by the school nurse or authorized CBHS personnel. I agree to release, indemnify, and hold harmless CBHS and its employees or representatives from any claim, liability, or expense arising from giving or failing to give the prescribed medication, including claims based on alleged negligence by CBHS or its employees. I am responsible for notifying the school in writing of any change in medication or its administration.

Parent/Guardian's Signature _____ Date _____