HOLY CROSS LUTHERAN SCHOOL

AUTHORIZATION FOR NON PRESCRIBED MEDICATION OR TREATMENT

To the Parent:
THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NON PRESCRIBED MEDICATION IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____
Name of Student

A. I am requesting permission for my child named above to use or receive the following over the counter medication(s).

   Medication:_____

   Dosage:_____

   Duration: _____

B. I will assume responsibility for safe delivery of the medication to school and removal from school.
C. I will notify the school immediately if there is any change in the use of the medication or treatment
D. I understand that the medication must be in the original container.
E. I release and agree to hold Holy Cross Lutheran Church and School, it's Board of Education, its officials and it's employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent Date

_____ _____
Mobile Telephone Numbers Work Telephone number

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above mentionedmedication(s) or treatment(s).

_____ _____

_____ _____

_____
Principal