Teurlings Catholic High School

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Parental Release Form

REQUEST FOR SCHOOL NURSE TO ADMINISTER OVER THE COUNTER MEDICATION

Child's Name: _____ **Grade:** _____

Drug Allergies: _____

Please indicate below which medications you authorize to be administered to your child in the event of an illness or incident.

Fever/ Pain:

☐Ibuprofen
☐Acetaminophen

Allergies/ Sinus/ Cold:

☐Benadryl
☐Cough Drops

Gastrointestinal Issues (Nausea, Vomiting, Diarrhea, Indigestion):

☐Pepto-Bismol
☐Generic Antacid/Tums

Please list any over the counter/non-prescription medications you DO NOT want administered to your child.

Medication: _____

Medication: _____

OR

☐ **I DO NOT** AUTHORIZE ANY MEDICATIONS TO BE ADMINISTERED TO MY CHILD.

I hereby release, relieve and discharge Teurlings Catholic High School and its employees from any and all liability for any injury or damage to health of said child arising out of or resulting from the necessity of said child having to take medications during school hours.

My signature authorizes school personnel to administer the medications indicated above, as stated on this form, to my child.

_____ _____

Parent Signature Date

PLEASE CONTACT OUR SCHOOL NURSE IF YOUR CHILD WILL BE TAKING PRESCRIPTION MEDICATION DURING SCHOOL HOURS OR IF THEY HAVE ANY MEDICAL CONDITIONS THAT NEED TO BE DISCUSSED.

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