



SAN JOSE
CATHOLIC SCHOOL

**Parental/Guardian Permission for the Administration of
NON-PRESCRIPTION MEDICATION**

Student _____ Grade _____

Name of Medication _____

Quantity _____

Dosing Information _____

I, _____, grant permission for the Clinic Aide
(Parent or legal guardian)

or the principal's designee to assist in the administration of this medication to my

child/legal ward, _____.
(Student's Name)

I certify that the non-prescription medication is in its original container and that it is necessary, according to my child/legal ward doctor's instructions, for this medication to be provided during the school day. I understand that this medication will be given only according to the directions listed above. Further, I agree to waive any claims of liability that may arise against any/all school, church or diocese personnel, relative to the administration of this medication to my child/legal ward according to these directions. I further understand that no later than the end of the school year any unused medication must be picked up or it will be destroyed.

Date

Signature of parent/legal guardian