Immaculate Conception Catholic School of Special Education

811 Telfair Street Augusta, GA 30901 706.722.9964 | icaugusta.org



Non-Prescription Medication

Student	This form is to be completed and signed by the paren	t/guardian authorizin;	g medication to be given to the stu-
labelled with the child's name. If any changes occur during the school year, a new form must be completed and returned to school. This form is good for one school year. Parent Permission Section (to be completed by parent/guardian) Student	dent during school hours. This form must be complete	ted for non-prescripti	on medications and returned to the
returned to school. This form is good for one school year. Parent Permission Section (to be completed by parent/guardian) Student			
parent/guardian) Student			
Student	returned to school. This form is good for one school	year. Parent Permissi	on Section (to be completed by
Teacher	parent/guardian)		
Emergency Contact Phone Physician's Name Phone Phone The first dose of medication should always be given at home in case of an adverse reaction. Please check the over-the-counter/non-prescription medication listed below that the school nurse may administer to your child according to the manufacturer's recommended dosage. It is understood that the medication (if available) is administered solely at the request of the parent and as an accommodation. Please check with the school nurse to see which medications are available for students and which medications you will need to supply. The school is not able to supply medication for frequent or daily use. Acetaminophen/Tylenol Antacids/Tums Antibiotic/Bacitracin ointment Benadryl/Diphenhydramine Cough drops Hydrocortisone cream 1% Thuprofen/Motrin Other Medication: Medication: Allergies If given as needed, describe/list indicators: Possible side effects I understand that the Immaculate Conception Catholic School, its employees or agents shall not incur any liability as a result of any injury arising from the self-administration of the medication by my child, shall exempt from liability and hold harmless school employees or agents against any claims arising out of the self-administration of medication by my child, and I understand that this authorization shall be effective for this current school year and must be renewed annually.	Student	DOB	Gender
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Parent/Guardian Signature Date	bility as a result of any injury arising from the self-adm from liability and hold harmless school employees or	ninistration of the med agents against any cla	lication by my child, shall exempt ims arising out of the self-
	Parent/Guardian Signature	Date	