Immaculate Conception Catholic School of Special Education
811 Telfair Street
Augusta, GA 30901
706.722.9964 | icaugusta.org

Non-Prescription Medication

This form is to be completed and signed by the parent/guardian authorizing medication to be given to the student during school hours. This form must be completed for non-prescription medications and returned to the school before the medicine can be given. All non-prescription medication must be in the original container and 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 _____ DOB _____ Gender _____
Teacher _____ Grade _____
Parent/Guardian _____ Phone _____
Emergency Contact _____ Phone _____
Physician's Name _____ 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%
____ Ibuprofen/Motrin

Other Medication: _____
_____
Dose _____Frequency _____
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.

Parent/Guardian Signature _____ Date _____