Sacred Heart Catholic School

540 N. 31st St. – Lincoln, NE 68503 – (402) 476-1783

2018-2019 Authorization for Administration of Medication

Revised 3-6-2018

Family Last Name: _____ Phone number: _____

Address: _____ Zip code: _____

Children's Names	Grade: 2018-19
1.	
2.	
3.	
4.	
5.	

I (we) as parent(s)/guardian(s) of the above named student(s) give permission for the personnel of Sacred Heart Catholic School to administer to my child(ren) the following non-prescription medication should it be necessary (mark all that apply):

Tylenol _____ Ibuprofen _____ Antacid _____ Cough drops _____

Antibiotic ointment _____ Anti-itch cream _____ Eye drops/saline solution _____

I (we) as parent/guardian of the above named student(s) authorize the personnel of Sacred Heart Catholic School to give my child(ren) prescription medication should it be necessary.

Yes _____ No _____

I (we) understand that both non-prescription and prescription medications will be sent in a container with a proper label that includes:

1. The name of the student
2. The name of the medication
3. The dosage and frequency of administration

All medications must be given school office personnel. All prescription medications require a physician's written order.

I (we) hereby release the personnel of Sacred Heart Catholic School from any liability arising from the administration of non-prescription and prescription medication.

Parent/Guardian Signature: _____ Date: _____