Bishop Neumann Catholic JR/SR High School
202 South Linden Avenue
Wahoo, NE 68066-2057
(402) 443-4151
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Authorization for Administration of Non-Prescription (Over-the-Counter) Medications

Student Name: _____Grade:_____
Parent/Guardian: _____ Daytime Phone#_____

I (We) as parent/guardian of the above named student authorize the personnel of Bishop Neumann JR/SR High School to give my child the following **non-prescription medication** should it be necessary. Dosage instructions from the bottle/container will be followed, unless otherwise specified by parent. Please note that doses over the amount listed on the label cannot be given without a written order from a licensed healthcare prover (MD/DO, PA, Dentist, or Nurse Practitioner).

Please indicate the following that apply:

1. Ibuprofen (Motrin, Advil) 200 mg ____1 or ____2 tablets every 4 to 6 hours

2. Acetaminophen (Tylenol) 325 mg ____1 or ____2 tablets every 4 hours
   OR 500 mg ____1 or ____2 tablets every 6 hours

3. Cough Drops ____

4. Antacids (Tums) ____

5. Topical ointment (Neosporin, triple antibiotic ointment, hydrocortisone) ____

Other medication my child may take with complete instructions, **parent to supply** (examples: decongestants, cough medicine, antacids, migraine or menstrual relief)
Name of Medication(s) _____

Medical Management Plan? Yes No (please circle)
(Required for asthmatic, anaphylactic and diabetic medications)

-This form will be kept on file for the current school year.
-I understand that it is my (our) responsibility to notify the school if my child becomes unable to take any of these medications during the school year.
-I (We) understand that if this form is not signed and returned to the school office, my child will **not** be given any medication at school. I (We) understand that all medications will be turned in to and stored in the office, unless a Medical Management Plan has been completed granting my (our) student permission to carry emergency medications on their person. I (We) accept ultimate responsibility for monitoring the effects and possible adverse reactions of these medications on my (our) child. I (We) therefore release Bishop Neumann School and its employees from all liability relating to the administration of non-prescription medication to my (our) child.

_____ _____
Parent/Guardian Signature Date

3/25/2019 Shannon Newburn RN

Date/Time	Medication/Dosage	Reason Given	Administered by