PROVIDENCE
CLASSICAL SCHOOL

AUTHORIZATION TO DISPENSE OTC MEDICATION

SCHOOL YEAR: _____

Family Last Name: _____

(Please Print Legibly)

PCS OVER THE COUNTER (OTC) MEDICATION POLICY:

- Families with students who need occasional medications agree to provide the medications to the nurse in their original (new), properly labeled containers. (Medicines may not be shared with anyone outside of the family.)
- OTC medicines will only be dispensed to those students with a signed Authorization to Dispense OTC Medication on file.
- The manufacturer's recommendations will determine dosage amounts based on the child's weight.
- PCS employees may not administer herbal medications, home remedies, or dietary supplements without a medical doctor's note. If these are dispensed, they must also come to school in labeled, original containers.

_____ I authorize any adult designated by Administration to dispense over-the-counter (OTC) medications to my child provided the medication has been supplied by our family per the PCS medication policy. I understand the OTC medications will be dispensed per the manufacturer's dosage instructions according to my child(ren)'s weight.

_____ I understand that expired medication, herbal medications, home remedies, or dietary supplements will not be dispensed without written authorization from my child's physician.

_____	_____
Student Name (Please Print Legibly)	Grade
_____	_____
Student Name (Please Print Legibly)	Grade
_____	_____
Student Name (Please Print Legibly)	Grade
_____	_____
Student Name (Please Print Legibly)	Grade
_____	_____
Student Name (Please Print Legibly)	Grade

WAIVER OF LIABILITY

I understand that this request is effective for the school year in which it is granted and must be renewed each subsequent year.

I acknowledge that the school and its agents shall incur no liability as a result of harm or injury arising from the dispensing of OTC medications provided by me. Further, I acknowledge that the school and its agents shall incur no liability as a result of harm or injury arising from the dispensing of medication per written instructions from my child's physician. I hold harmless Providence Classical School and its employees or agents against any claims.

Date: _____ Parent/Guardian Signature: _____