# CAPITAL CHRISITAN HIGH SCHOOL

9470 MICRON AVENUE SACRAMENTO, CA 95827
PHONE 916/856-5611 FAX 916/856-5960

## PARENT RELEASE FOR NON-PRESCRIPTIVE OVER-THE-COUNTER (OTC) MEDICATION IN SCHOOL

**PLEASE NOTE: THIS FORM MUST BE COMPLETED EACH SCHOOL YEAR FOR EACH MEDICATION**

Student's Name _____ Grade _____ Date _____

My child will need to take non-prescriptive, over-the-counter medication. I understand that non-prescription medication shall be **brought to the school office in the original, sealed container(s) and labeled with my student's name and date of birth**.
ALL MEDICATION MUST BE KEPT IN THE NURSE'S OFFICE.

*I, the undersigned, request that non-prescriptive, over-the-counter medicine be administered to said child by a designated member of the school staff in accordance with instructions outlined below.*

*I agree as soon as my child no longer needs to take this non-prescriptive, over-the-counter medication, I will personally retrieve the medication from the school office.*

*In agreeing to have the school administer my son's/daughter's over-the-counter medication, I voluntarily agree to release, discharge, and hold harmless Capital Christian School and its officers, agents and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which causes my child's illness, injury, death, and damages of any nature in any way connected with the administration of my child's medication.*

*I understand that the major responsibility for a child taking medication rests with the child and his/her parents/guardians, and that I am required to personally bring the medication to school(preschool through 6$^{th}$ grade).*

*I understand that students in grades 7 through 12 may bring their own medication to the school office.*

**Please note:** The School Nurse is not always available on the school site, therefore, over-the counter medications should be administered at home whenever possible. If over-the counter medication must be administered during school hours, please complete the information below:

Medication _____ Dose _____

Time to give medication: _____ OR _____Only as needed every _____Hours

Route ____oral ____inhale ____eye ( R L ) ____ear ( R L ) ____ Other_____

Reason _____ Side Effects_____

Give Medication until: _____ (date) OR _____ until notified

Special Instructions_____

Home Phone_____Work Phone_____Cell Phone_____

**Parent/Guardian Signature _____ Date _____**