9th 10th 11th 12th
Grade Level (Circle One)

MARIST HIGH SCHOOL
PARENT/GUARDIAN PERMISSION AND AUTHORIZATION

______________________________ ________________________
Student's Name (Last, First, Middle) Date of Birth

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, I hereby authorize the school nurse or her designee, on my behalf, to administer or to attempt to administer to my child on an as needed basis the following:

Check all that apply:

______***Ibuprofen 200 mg.-1-2 tablets by mouth every 4-6 hours as needed for temporary relief of minor aches and pain due to the common cold, arthritis, muscle aches, headache, menstrual cramps, and fever. (Max: 6 tablets in a 24 hr. period). Generic for: Motrin or Advil.***

______***Acetaminophen 500mg – 2 tablets by mouth every 4-6hours as needed for temporary relief of minor aches and pains associated with headache, muscle aches, minor arthritis pain, toothache, common cold, menstrual cramps and fever. (Max dose: 8 tablets in 24 hrs.)Generic for: Tylenol.***

______***Antacid(Calcium carbonate 420mg)-2 tablets chewed by mouth every 2-3 hours as needed for relief of acid indigestion, sour stomach, heartburn and upset stomach. Generic for: Tums***

______***Sinus Decongestant (Phenylephrine HCL 10mg.) – 1 tablet every 4 hours as needed for temporary relief of nasal congestion due to common cold, hay fever, other respiratory allergies and nasal congestion associated with sinusitis. (Max: 6 tablets in a 24 hour period)***

I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the school, or any employees or agents arising out of the administration or attempted administration. In addition, I agree to hold harmless and indemnify the school, and employees or agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempted administration of said medicine.

______________________________ ________________
Parent/Guardian Signature **Date**

______________________________ ________________
Parent/Guardian Name (Printed) **Physician Signature**

______________________________ ________________________
Home Telephone **Physician Name (Printed)/Phone #**

Health Form C – (Return to Health Services)