St. Wenceslaus Catholic School
108 N. Linden Street
Wahoo, NE 68066
(402) 443-3336, Fax: (402) 443-5551

St. John Nepomucene Catholic School
202 S. Linden Street
Wahoo, NE 68066
(402) 443-4151, Fax: (402) 443-5551

Student Name: ____ **Grade**: ________ **School Year**: _________________

Parent/Guardian: ______________________________ **Daytime Phone#**___________________________

I (We) as parent/guardian of the above-named student authorize the personnel of Saunders Catholic Schools 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:

____ Ibuprofen (Motrin, Advil) _____ Chewable **OR** _____ Tablet/Caplet (Per Label Instructions)
____ Acetaminophen (Tylenol) _____ Chewable OR _____ Tablet/Caplet (Per Label Instructions)
____ Cough Drops (Generic or Name Brand)
____ Topical Ointment (Neosporin, Triple Antibiotic Ointment)

The above medications may be taken for:
_____ Headache _____ Dental/Orthodontic _____ Muscle or Body Aches _____ Menstral Pain
___ Other (Please Explain):

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) ____
Directions:

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 Saunders Catholic Schools and its employees from all liability relating to the administration of non-prescription medication to my (our) child.

____ ______________________________
Parent/Guardian Signature Date

Updated: 05/2023 T. Rubendall RN

Date/Time	Medication/Dosage	Reason Given	Administered by

Initials: Signatiure: ________ ______________________________

Initials: Signature: ________ ______________________________