PARENT OR GUARDIAN'S REQUEST FOR ASSISTANCE WITH NON-PRESCRIBED OR OVER-THE-COUNTER MEDICINE, WAIVER OF CLAIMS, AND RELEASE OF LIABILITY

PLEASE PRINT

Name of Student (First, MI, Last Name)	Name(s) of Parent(s) or Guardian(s) (First, MI, Last Name)	
Telephone Numbers where parents/guardians can be reached during the school day. Include cellular and pager numbers.		
Name of School	Grade	School Year

Name of non-prescribed medication:	
Condition for which medication is to be given	
Dose	Schedule of doses
The medication is to be continued as above unless the following precautions and possible reactions to medication occur:	

I, the undersigned, hereby request the school, mentioned above, to assist in the matters set forth on the statement on this form. I assure the school that my child may safely take the non-prescription medication described on this form, and I accept all consequences as a result of my child taking this medication. I will notify the school immediately if there is a change in my child's medication schedule. I understand it is my responsibility to send the medication to the school office in its original container labeled with my child's name. I understand that the school reserves the right to discontinue assistance to the child in the child's taking of non-prescribed medication at school.

I request designated school personnel to assist my child when my child takes his non-prescribed medication. I understand and accept the fact that school personnel who assist my child are not likely to have had medical training. I understand that in case of an error or adverse reaction to medication, the school resources are limited to calling emergency services (911) and the parent or guardian.

I understand that the school is not obligated to store or assist my child when my child takes medication, and that the school prefers that medication be scheduled outside of school hours whenever possible. Therefore, in consideration of this assistance, I release and discharge the school from any and all claims for liability or responsibility for death, illness, adverse reactions, personal injury, or property damage that my child or I may suffer as a result of this arrangement, whether or not such injuries or damage are caused by negligence (either active or passive) of the school. This waiver of all claims and release of the school also releases the Diocese of Fresno Education Corporation, The Roman Catholic Bishop of Fresno (a corporate sole), the Diocese of Fresno, all other Diocese of Fresno schools, all parishes, all affiliated organizations, and all of their officers, clergy, agents, and employees.

Date	Signature of Parent or Guardian
Date Received at School	Signature of School Representative that received this request
Date Request Approved	Approved By

This form must be completed and returned to the school before any non-prescribed medication may be taken at school. This form may only be used for one medication. Use additional forms for other medications. This request will be effective for one school year only and will be maintained in your child's medical file.

Approved: 000830