



BISHOP CHATARD HIGH SCHOOL

A Faith Community. Learning. Leading. Serving.

Dear Parent/Guardian,

Please find attached a medication permission slip. This form needs to be completed with your child's name and the over the counter medications they may receive if needed along with the dose they are allowed to have.

The nurse's office will have Acetaminophen and Ibuprofen available if they are listed on the form. Any other over the counter medicine that your child may have (Benadryl, cold remedies, etc) must be provided by you in its original bottle and sent into school with the completed form. Please have your child's name clearly marked on the bottle.

If you need or would like to have your child's prescription available to them you must send in the prescription in the bottle with the prescription information on it.

Thank you for your cooperation.

J. Louis R.N. School Nurse



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_____, has permission to take the following medication(s) as needed:
(Student's full name)

(Name of medication, dose and frequency)

_____-_____
(Date valid through)

(Parent or Guardian Signature)

Thank you Ms. J. Louis R.N. School Nurse
317-251-1451