Riviera Preparatory School

Medication Authorization Form
2026-2027 Academic Year

Student Name: _____ Date of Birth:_____ Grade:_____

Any designated representative of Riviera Preparatory School Holdings, LLC (the "School") may administer medications during the school day and while participating in school activities. This authorization form must be completed entirely, signed, and returned to the school before any prescription or over-the-counter medication may be administered. NOTE: A separate form must be completed for each medication prescribed or any change.

The medication should be brought to school prior to the day of the first administration, in the original container appropriately labeled by the pharmacy. Non-prescription medication must be in the original container, labeled with the student's name, the dosage, and the time the medication is to be administered. Parents are responsible for prescription refills and for ensuring that the school has an adequate supply of medicine. The parent should list any and all precautions to be followed on this form. It is the Parents' responsibility to notify the front office staff of any change in their child's medical status or medication. The Parent will also be responsible for ensuring that medicines provided for the school have not expired.

I. Prescription Medication

Name of Medication: _____
Route (oral, topical, other): _____
Dosage (number of milligrams):
_____

If medication is to be given at scheduled times, at what times(s)? _____
If medication is to be given "when needed", when would it be indicated, and how many times can it be given?
_____
If applicable, is the student authorized to carry and self-administer asthma inhalation medication, epinephrine auto-injection, or pancreatic enzyme supplement☐ YES ☐ NO
List any significant side effects of the medication: _____
Length of time (duration) medication is recommended: _____

II. Over-The-Counter Medication

On occasion, and with discretion, the front office staff or an administrator may offer the student the following over-the-counter medications (brand name or generic equivalent) if needed. The medication will be administered in accordance with the manufacturer's recommended dosage, unless otherwise indicated by the student's parent. Please check all those approved. Please note that if none are checked, the School will NOT administer any over-the-counter medications to your child.

Acetaminophen
Cetirizine
Ibuprofen
Cough drops
Diphenhydramine
Other: _____

I request that the above medication or procedure be administered to my child. I HEREBY WAIVE AND RELEASE THE SCHOOL, its Trustees, agents, employees, volunteers, chaperones and invitees, including parents of students assisting with any activity ("RELEASEES"), FROM ANY AND ALL CLAIMS, INJURIES, SUITS, LOSSES, DAMAGES, CAUSES OF ACTION OR OTHER LIABILITIES WHICH MAY ARISE in connection with the administration or lack of administration of the foregoing medication(s) and/or procedure(s), EVEN IF CAUSED BY THE NEGLIGENCE OF THE SCHOOL ITS RELEASEES. FURTHER, I HEREBY ALSO AGREE TO INDEMNIFY AND HOLD HARMLESS RELEASEES FROM ANY AND ALL CLAIMS, SUITS, LOSSES, DAMAGES, CAUSES OF ACTION OR OTHER LIABILITIES, including but not limited to all damages and all expenses of litigation and/or settlement/release, by reason of the administration or lack of administration of the foregoing medication(s) and/or procedure(s), EVEN IF CAUSED BY THE NEGLIGENCE OF THE SCHOOL OR ITS RELEASEES.

_____	_____	_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Parent/Guardian Name	Parent/Guardian Signature	Date