Hinsdale Central High School
MEDICATION AUTHORIZATION FORM
PHONE 630-570-8595 FAX 630-570-8599

Student Name: _____ Class/ID: _____ /_____

TO BE COMPLETED BY THE PHYSICIAN: (please print)

All medication (prescription or nonprescription, including generic Tylenol and ibuprofen) requires authorization **each school year**. It is the parent's responsibility to update student health information in the event of any change.

***Please note**: Only **generic** Tylenol, Advil, or Motrin will be dispensed in the Health Office. If non generic is ordered, parent must supply the medication. **If medication below is not advised, delete or amend as needed**.*

Medication *Required* during School	**Dosage/Route**	**Time and Frequency**
Generic Tylenol	325-650 mg po	every 4-6 hours as needed
Ibuprofen	200-400 mg po	every 4-6 hours as needed

Other Medication *Required* during School	**Dosage**	**Time and Frequency**

Diagnosis requiring medication(s): _____

Intended effect/Possible side effects: _____

Other medication student is taking: _____

Medication student may carry and self-administer: **Inhaler, Insulin or Epi-Pen** (circle if applicable). Please contact the school nurse at 630-570-8595 for details.

Self-Administered Medication: such as medication for asthma, diabetes, or severe allergy: I or a member of my staff has instructed the above student in the proper administration of the self-administered medication. He/she understands the need for the medication, the appropriate response, and the necessity to report to school personnel any unusual side effects or lack of appropriate response. The student is capable of using this medication independently.

Physician's Signature _____ **Date** _____

Physician's Name _____ **Phone**_____ **Fax**_____

Parent/Guardian's Authorization By signing below:

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 or in the event of a medical emergency, I hereby authorize Hinsdale Township High School District 86 and it employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer) the lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than the school nurse, and specifically consent to such practices. I further acknowledge and agree that, when lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from any and all claims, damages, and causes of action or injuries, except a claim based on willful and wanton conduct, incurred or resulting from the administration or self-administration of medication.

Parent/Guardian's Signature _____ Date _____

Address _____ Phone _____