Authorization for Non-Prescription Medication Administration 2023-24

Student's Name: _____ DOB: _____ Grade: _____

Absolutely no medications [non-prescription (over the counter) or prescription] will be administered by either Cannon School personnel or self (student) without the written authorization of a physician/designee and parent. **Dosages for all medications will be administered according to manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. Please submit a new form during the school year if there are changes or additions**.

To be completed and signed by Healthcare Provider and parent/guardian.

Please check the medications to be administered at school:

___Acetaminophen(Tylenol)	___Ibuprofen (Advil, Motrin)
___Antacid(Tums)	___Polysporin, Triple antibiotic ointment
___Benadryl (Diphenhydramine) liquid or capsules for mild allergic reactions	___Refresh Plus preservative free lubricant eye drops
___ Benadryl Cream (Diphenhydramine HCL) 1% or 2%, Hydrocortisone Cream	___After Bite for bee/insect sting
___Calamine lotion	___Cough Drops (3rd Grade and older)

I give my permission for the Cannon School Nurse/ employee to administer the above over the counter medications during school hours. On behalf of my child, I absolve Cannon School, their agents, and employees and the undersigned physician from any liability whatsoever that may result from my child receiving these medications.

All of the above information has been completed to the best of my knowledge.

I understand significant health information may be shared with my child's teachers to ensure his/her safety while at school.

I authorize my child's Healthcare Provider and Cannon School's Nurse to discuss health concerns and/or exchange information pertaining to the information given on this form.

_____ _____

Signature of Healthcare Provider Date

_____ _____

Signature of Parent or Guardian Date