SACRED HEART
THE ACADEMY & HARDEY PREP

PERMISSION TO ADMINISTER MEDICATIONS

Student's Name: _____ **Grade**_____

In accordance with State of Illinois guidelines (105 ILCS 5/22-30 and PA 98-0795) and school policy, all medications must be authorized by a licensed Illinois health care provider. Signatures from both the prescribing health care provider and the parent/guardian are required. **Medication forms are required on an annual basis.**

To be completed by prescribing Physician, Nurse Practitioner, or Physician Assistant:

A. NON-PRESCRIPTION MEDICATIONS

Please check the medications the student is authorized to receive.

- ☐ **Acetaminophen** (*Tylenol)*
- ☐ **Ibuprofen (***Advil* or *Motrin)*
- ☐ **Diphenhydramine HCl** (*Benadryl)*
- ☐ **Calcium Carbonate Antacid** (*Tums)*
- ☐ **Simethicone** (Gas X)
- ☐ **Triple Antibiotic Ointment**
- ☐ **Hydrocortisone Cream 1%**
- ☐ **Antihistamine Spray**
- ☐ **Topical Analgesic**
- ☐ **First Aid Antiseptic Liquid**
- ☐ **Saline Eye Rinse**

B. PRESCRIPTION MEDICATIONS

Medication: _____

Dose: _____ Frequency/Time of Administration: _____

Intended effect: _____

Possible side effects: _____

Start date: _____ Stop date: _____

Medication: _____

Dose: _____ Frequency/Time of Administration: _____

Intended effect: _____

Possible side effects: _____

Start date: _____ Stop date: _____

Prescribing Health Care Provider signature required for both non-prescription and prescription medications

Health Care Provider Signature: _____ **Date:** _____

Printed Name of Health Care Provider : _____

Address: _____ Phone Number: _____

To be completed by Parent/Guardian:

I give permission for my child to receive the above medications as directed.

Parent/Guardian Signature: _____ **Date:** _____

Printed Name of Parent/Guardian: _____

(Prescription medication to be administered at school should be brought to the Health Office by the parent/guardian in the original container with the prescription label affixed.)