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.)