



# School Medication Authorization Form Over the Counter Medications

Revised: January 2023

Illinois State Law requires written permission by a parent/guardian and a licensed healthcare provider for the administration of any medication at school. Please complete this form and have your student's health care provider identify any over-the-counter medication(s) you would like your student to have permission to take, while at school.

**This form will be kept on file in the Nurses' Office and will be valid until graduation.**

## Part 1: Student Information

Name (First, Middle, Last)	Student ID Number	Home School
		<input type="checkbox"/> GBN <input type="checkbox"/> GBS

## Part 2: Healthcare Provider to Complete

Please identify which medication you would like your child to have permission to take during the school day. The Nurses' Office stocks a supply of the medications listed below.

- Advil 200mg (Ibuprofen), 1-2 Tablets, Every 6 Hours as Needed
- Benadryl 25mg (Diphenhydramine HCl), 1 Capsule, as Needed
- Tylenol 325mg (Acetaminophen), 1-2 Tablets, Every 6 Hours as Needed
- Tylenol Extra Strength 500mg (Acetaminophen), Every 6 Hours as Needed

Healthcare Provider Name ( <i>Type/Print</i> )	_____	Office Phone Number:	_____
Healthcare Provider Signature:	_____	Date:	_____

## Part 3: Waiver of Liability and Certification by Parent/Guardian

By signing below, I agree 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 Glenbrook High School District 225 and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of Glenbrook High School District 225), over-the-counter medication in the manner described above.

I agree to indemnify and hold harmless Glenbrook High School District 225 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of over-the-counter medication.

Parent/Guardian Name ( <i>Type/Print</i> )	_____	Emergency Phone Number:	_____
Parent/Guardian Signature	_____	Date:	_____