Nurse Phone: 708.467.5647 **Nurse Fax: 708.467.5672**

Argo Community High School
OTC (Over the Counter) Medication Authorization Form

(to be completed annually and kept in the school health office)

Student Name: _____ Birthdate: _____ ID Number _____

Parent/Guardian: _____

Home Telephone: _____ Emergency Telephone: _____

Illinois state law requires written permission by a parent/guardian and licensed healthcare provider for administration of any medication at school. Please complete the following information. BY SIGNING THIS FORM, I AGREE THE MEDICATIONS LISTED BELOW CAN BE ADMINISTERED BY THE SCHOOL NURSE AND/OR DESIGNATED SCHOOL EMPLOYEE.

Any Known Allergies: _____

Any Chronic Health Conditions: _____

Other Medications Taken: _____

Acetaminophen 250, 1-2 tablets by mouth, every 6 hours as needed

Ibuprofen 200 mg, 1-2 tablets by mouth, every 6 hours as needed

Menthol Cough Drops, 1 cough drop by mouth, every 3 hours as needed

Tums, 150 mg, 2-4 tablets by mouth, every 6 hours as needed

Diagnosis Requiring Medication: _____

Intended Effect of Medication: _____ Time for Re-Eval: _____

Parent/Guardian Authorization and Signature

I hereby confirm 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 Argo Community High School and its designated employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the designated employees and agents of Argo Community High School), lawfully prescribe medication in the manner described above. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against Argo Community High School, its employees and agents, arising out of the administration of, or attempt to administer, such medication. In addition, I agree to hold harmless and indemnify Argo Community High School, its employees and agents, jointly and severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of, or attempt to administer, such medication.

In the event that Argo Community High School's designated personnel observe an overuse or dependency upon medications, the parents/guardians will be contacted and procedures reviewed and modified as appropriate.

Parent/Guardian Signature: _____ Date: _____

Physician Name:_____ Phone/Emergency Phone: _____

Physician Signature: _____ Date: _____