

# Medication Administration Authorization

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I agree to hold The Swallow School District, its employees, and Agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of medication noted below while at school. I hereby authorize the district nurse to contact the physician as needed. I understand that ALL medication has to be provided in its original container. I understand that this form is only valid for the school year in which the date signed falls within.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## OVER-THE-COUNTER MEDICATIONS

Medication Name	Route	Dose	Indications on when to be given at school

Swallow School's Health Room stocks the following medications in tablet form for **4<sup>th</sup> grade and up**. The health room DOES NOT stock liquid medications.

Please INITIAL next to the medication that you authorize staff to administer:

\_\_\_\_ Ibuprofen 200mg, (generic Advil) 1 or 2 tablets every 6 hours as needed for discomfort. Ibuprofen will not be administered more than 10 days a month without documentation from a physician.

\_\_\_\_ Acetaminophen 325mg (generic Tylenol), 1 or 2 tablets every 4 hours as needed for discomfort. Acetaminophen will not be administered more than 10 days a month without documentation from a physician.

\_\_\_\_ Diphenhydramine Hydrochloride 25 mg (generic Benadryl), 1 or 2 capsules every 4 hours as needed for allergic reaction or hay fever.

\_\_\_\_ Allaquix (Calcium Alginate Hemostat, Stop Bleeding Gauze), use at time of nosebleed to lessen the duration. (Cannot be administered to students with a shellfish allergy.)

## PRESCRIPTION MEDICATIONS

Medication Name	Route	Dose	Frequency	Side Effects

\_\_\_\_ Please check if student may self-carry inhaler

\_\_\_\_ Please check if student may self-carry epi-pen  
(Epi-Pen still needs to be supplied for the health room)

Practitioner's Printed Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_

Fax: \_\_\_\_\_