

Medication Authorization

Health Office
847-256-7660 ext 248
FAX 847-256-3726

Student Name:

DOB:

Allergies: _____

PRESCRIPTION MEDICATIONS: MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR

All medications must be brought to Health Office by parent/guardian in a prescription labeled container.

Allergy, Asthma and Diabetic Medications: With physician and parent authorization, a student may carry a labeled inhaler, EpiPen, Benadryl, Insulin, glucagon and diabetic supplies. Back-up medication stored in the Health Clinic is encouraged in case of emergency.

Medication: Dosage: Route: Amount to take: Frequency:

1. _____
2. _____
3. _____
4. _____

Student may carry medication. ☐ Yes ☐ No Student may self administer medication. ☐ Yes ☐ No

NON-PRESCRIPTION MEDICATIONS: The following Over-the-Counter (OTC) medications are kept in stock: Ibuprofen (Motrin), Acetaminophen (Tylenol), Diphenhydramine (Benadryl), and Tums. All other non-prescription medications must be brought to the clinic by a parent/guardian in a manufacturer-labeled container.

Over-the-counter medication must be renewed at the beginning of each school year.

Please authorize medication administration by checking the appropriate boxes.

Medication: Dosage: Route: Amount to take: Frequency:

1. ☐ Motrin 200mg each PO 2 tablets every 6 hours as needed
2. ☐ Tylenol 325mg each PO 2 tablets every 4 hours as needed
3. ☐ Benadryl 25mg each PO 1-2 tablets for allergy symptoms or allergic reaction
4. ☐ Zyrtec 10mg each PO 1 tablet for allergy symptoms or allergic reaction
4. ☐ Cough Drop

OTC End Date : _____

Address / Office Stamp

Medical Provider Signature _____

Phone Number: _____ Date: _____

I hereby authorize the school staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Tort Immunity Act, protects staff from liability arising from actions consistent with this plan. I also hereby authorize the school staff to disclose my daughter's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic, or asthmatic reaction, or emergency treatment of my child and for the implementation of this plan.

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