

Permission for Medication Administration

This form must be signed by a **Physician and a Parent/Guardian** and uploaded to Magnus Health in order to be compliant with ISBE. This includes any over the counter medications such as Tylenol, Ibuprofen, Peptobismol and Benadryl. This form is effective only for the school year for which it is granted.

Student Name: _____ Date of Birth: _____

Part 1: Please Check the Approved Over the Counter Medications to be given at DCP

- ☐ Acetaminophen - Apap/Acetaminophen
- ☐ Ibuprofen - Pain Reliever
- ☐ Pepto-bismol - Bismuth Subsalicylate
- ☐ Antihistamine - Diphenhydramine/Diphen
- ☐ Cough Drops - Menthol Cough Drops
- ☐ Bacitracin Ointment - Triple Antibiotic Ointment
- ☐ Saline - Saline Eye Rinse
- ☐ Benadryl cream - Benadryl

***Physician Signature:** _____

Parent Signature: _____

Part 2: Approved Prescription Medications to be given at School:

Medication: _____

Health Condition for which Medication is Prescribed: _____

Dose/Route: _____

Possible Side Effects: _____

Time/Frequency of Administration: _____

***Physician Signature:** _____

For Diabetes Monitoring Supplies, Asthma Medication or Epinephrine Auto-Injector Only:

I authorize DePaul College Prep and its employees to allow this student to carry and self-administer their medications for allergies, asthma, and/or diabetes.

- ☐ **YES**, the student may self-carry and self-administer
- ☐ **NO**, the student may not self-carry or self-administer

APPROPRIATE ASTHMA ACTION PLAN, ALLERGY ACTION PLAN, or DIABETES ACTION PLAN has been uploaded to Magnus. ☐ Yes ☐ No

Part 3: This Section to be Completed by Parent/Guardian

I give permission for my child to receive the above medication at school according to DCP policy. I understand that medication as prescribed above for a student will be stored in a locked cabinet in the nurse's office. All medications that need to be stored in the nurse's office must be brought in by the parent/guardian in the original prescription-labeled container. I understand that the student is responsible for making timely visits to the nurse's office for their medication; they will not be reminded. I understand that the nurse will supervise the student's self-administration of their prescribed medication. I understand that I may terminate consent for such administration of medication at any time, in writing. I will notify the school immediately if my child's health status changes. I understand that medication/health information may be shared with Depaul College Prep staff on a need-to-know basis.

I acknowledge the guidelines listed above and authorize school personnel to administer this medication to my child.

☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____