

AUTHORIZATION FORM FOR ADMINISTERING MEDICATION AT SCHOOL

Student Name _____ Age _____ Grade _____ Teacher _____

I request /authorize SCHOOL DISTRICT 145 to give medication to my student in accordance with the instructions written below, from this date forward until the end of the current year unless otherwise notified. I understand that trained unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication. ***As indicated by the handbook, an authorization form must be filled out before any kind of medication will be administered. **ALSO all prescription medication must be brought in by an adult, in the original container. Prescription medication brought in by a student will not be administered.**

PLEASE NOTE: OVER THE COUNTER MEDICATIONS WILL BE GIVEN ONLY FOR REASONS STATED, SO PLEASE LIST ALL REASONS TO GIVE MEDICATION.

Please mark all the would apply

***Over-the-counter medications (Tylenol/Acetaminophen, Advil/Ibuprofen, cough syrup, cough drops, etc.)

***Medications will not be given in larger doses more often than directed by manufacturer without a doctor's note.

<u>Name of medication</u>	<u>Dose</u>	<u>Time(s) to be given</u>	<u>Reason for Providing Medication(s)</u>
Example: Advil	1 Tablet	As needed	headaches, toothaches, sprains
Example: Robitussin syrup	2 tsp	12:35 (lunch)	cough, sore throat

*Children's acetaminophen (Tylenol), regular acetaminophen, and the sore throat spray are available in the health office

Acetaminophen _____ (Tylenol)	_____	_____	_____
Ibuprofen _____ (Advil)	_____	_____	_____
Sore throat spray _____	_____	_____	_____
Cough drops _____	_____	_____	_____
Other _____	_____	_____	_____

Prescription medications (pills, syrups, inhalers, creams, eye/ear drops, etc.)

<u>Name of medication</u>	<u>Dose</u>	<u>Time(s) to be given</u>	<u>Reason for Providing Medication(s)</u>
Example: Amoxicillin	250 mg 1 tab	2:00 p.m.	illness
Example: Albuterol Inhaler	2 puffs		as needed difficulty breathing/asthma
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Possible side effects from any of the above medications _____

Emergency procedures/phone numbers in case of serious side effects _____

I request and authorize that the above named student be provided the above identified medication with the instruction indicated above as there exists a valid health reason which makes providing it advisable during the school hours.

Parent/Guardian Signature

Date