

SCHOOL MEDICATION AUTHORIZATION FORM

Also for the overnight field trips: 5th grade Outdoor Education or 8th grade Cleveland Tour

Required for all students
PRESCHOOL, K-8TH

Elementary School Phone: 708-246-4700
Elementary School Fax: 708-246-4625

Middle School Phone: 708-246-3210
Middle School Fax: 708-352-0092

NAME _____ GRADE _____ DOB _____

PRESCRIPTION MEDICATION, Dosage and Frequency, **Physician Signature**

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

"OVER THE COUNTER" Medications approved for student (please checkmark each type for approval): **Physician Signature required**

Acetaminophen (Tylenol) Ibuprofen (Advil, Motrin) Anti Diarrhea Anti-itch (Calamine) Antacids (Tums) Advil /Tylenol Cold +Sinus
 Anbesol Benadryl allergy tabs/(Spray for reaction) Cough drops Cold medication Cough suppressant Chloraseptic (Sore Throat Spray)
 Contact solution Rewetting drops (contacts) Eye Drops (Visine reg. or allergy) Expectorant Nasal Spray Excedrin Decongestant

Other

I do not want any medications given to my child during school hours. I understand by checking this space that I am willing to come to school to administer medications as needed.

Note - unless specified, dosage will be administered as per directions on medicine container

ASTHMA/INHALER SECTION Allergic to _____

Medication/Inhaler _____ Dosage _____ q _____ Hours

Neb Treatment- Name/Medication _____ Dosage _____ q _____ Hours

ASTHMA ACTION PLAN Peak flow meter – My Personal Best = _____

***Green Zone** – Breathing is easy, Can play, Work without symptoms* **PEAK Flow Range 80%-100%** of Personal Best

Medication/Nebulizer _____ Dose _____ Freq _____ Hours _____

***Yellow Zone**- Breathing easy, Coughing or Wheeze, Chest tight, SOB, **PEAK Flow Range 50%-80%** of Personal Best

Medication/Nebulizer _____ Dose _____ Freq _____ Hours _____

***Red Zone** Medicine NOT working, Nose open wide to breath, Breathing is hard and fast, Trouble walking and talking, Ribs show

If Symptoms do not get better Call 911 **PEAK Flow Range below 50%**

Medication/Nebulizer _____ Dose _____ Freq _____ Hours _____

EPIPEN EMERGENCY PLAN SECTION Please note: each body system must be filled out

Allergic to:

Medication & Dosage:

Epipen 0.3mg Epipen Jr. 0.15mg Twinject 0.3mg Twinject 0.15mg Benadryl 25mg- 50mg po

Treatment:

Mouth: Itching, tingling, or swelling of lips, tongue, mouth

Skin: Hives, itchy rash, swelling of the face or extremities

Gut: Nausea, abdominal cramps, vomiting, diarrhea

Throat: Tightening of throat, hoarseness, hacking cough

Lung: Shortness of breath, repetitive coughing, wheezing

Heart: Thready pulse, low blood pressure, fainting, pale, blueness

Other: _____

If reaction is progressing (several of the above areas affected)

CALL 911, CALL PRINCIPAL, CALL PARENTS

GIVE

GIVE

GIVE

GIVE

GIVE

GIVE

GIVE

GIVE

EPIEN TWINJECT BENADRYL

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Parent signature below also grants permission for medical release of information to School Nurse to obtain Physician Signature if needed

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Pleasantdale School District 107 and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the District), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a registered nurse and specifically consent to such practices. 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 the District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts of said medication.

X

Physician Signature + Date

X

Parent signature + Date