

# SCHOOL MEDICATION AUTHORIZATION FORM

Overnight field trips: 5<sup>th</sup> grade Outdoor Education or 8<sup>th</sup> grade Cleveland Tour

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

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

**Required: PRE-K thru 8th**

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_ DATE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ EMERGENCY PHONE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

PHYSICIAN NAME AND PHONE: \_\_\_\_\_

ALLERGIES \_\_\_\_\_ DIAGNOSIS \_\_\_\_\_

**LIST DAILY MEDICATIONS** \_\_\_\_\_

## TO BE COMPLETED BY STUDENT'S PHYSICIAN: all sections

**PRESCRIPTION MEDICATION**, Dosage and Frequency, **Physician Signature** \_\_\_\_\_ **M.D. Initials** \_\_\_\_\_ **required**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Dr. ( please check box if you approve) that when you prescribe any prescription medications throughout the school year, we(nurse) are able to administer one dose during school hours** **MUST INITIAL ABOVE**

**"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**

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 severely, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts of said medication.

**PARENT SIGNATURE (REQUIRED)** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PHYSICIAN SIGNATURE (REQUIRED)** \_\_\_\_\_ **Date:** \_\_\_\_\_