THIS FORM MUST BE TURNED IN AT REGISTRATION

MEDICATION AUTHORIZATION FORM

This side must be completed

☐ **I DO *NOT* WANT ANY MEDICATION GIVEN TO _____________________________Grade_______**

Parent/Guardian Signature:____Date:____________

A check in this box indicates completion of this side of form.

●●

OR

This portion below must be signed annually before any medication administration is allowed.

CONSENT FOR ADMINISTRATION OF HEALTH OFFICE MEDICATIONS

To be filled out annually by parent/guardian

Student Name____Grade_____________

Medication Allergies____

List medications this student takes regularly____

Health conditions____

Please check any medications you wish to be made available to this student under nursing discretion:

For headaches/fever/muscle aches/menstrual cramps/pain:

- ☐ Acetaminophen 325 mg (Generic equiv. to Tylenol) 2-3 tabs every 4 hours as needed
- ☐ Ibuprofen 200 mg (Generic equiv. to Advil/Motrin) 1-2 every 4-6 hours as needed

For mild stomach discomfort:

- ☐ Antacid (Tums, Pepto Bismol or generic equivalent) 2 tabs
- ☐ Antidiarrheal (Generic equivalent to Immodium)

For mild allergic reactions:

- ☐ Diphenhydramine 25 mg (Generic equiv. to Benadryl) 1-2 caps every 4 hrs as needed

I, the parent/guardian of ______________________________________, hereby authorize Centralia High School District 200, and its employees and agents, in my behalf and in my stead, to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication and non-prescribed medication in the manner described above. I further acknowledge and agree that, when the lawfully prescribed and non-prescribed medication is so administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to indemnify and hold harmless the School District, its employees and agents, either jointly or individually, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration of said medication.

I give permission for my child to receive any medication indicated above as deemed necessary by the school nurse. I understand that generic equivalent medication may be used. Whenever possible, arrangements should be made so that medications can be given at home.

Parent/Guardian Signature:____Date:____________