ARCOLA COMMUNITY UNIT SCHOOL DISTRICT #306

Over the Counter Medication Policy

Phone: 217-268-4963 Fax: 217-268-4719

STUDENT NAME:_____

GRADE?TEACHER: _____ DATE OF BIRTH:_____

Over-the-counter medication will be administered by the school nurse only after receiving written permission from both the parent/guardian and physician. The school will provide generic forms of Ibuprofen (Advil, Motrin); acetaminophen (Tylenol); diphenhydramine (Benadryl); etc. to be administered by the nurse at her discretion depending on need and physician orders. If your child needs children or junior dosage, it will need to be provided by the parent/guardian to the school nurse.

If you wish for your child to receive the following medications at school, please a check the appropriate item below and sign and date. In addition, this form will need to be signed and dated by the student's physician.

_____ Ibuprofen (Advil, Motrin, 200 mg tabs or 100 mg/mL) Dose: _____ Daily as Needed

_____ Acetaminophen (Tylenol, 325 mg tabs or 160 mg/5mL) Dose_____ Daily as Needed

_____ Diphenhydramine (Benadryl, 25 mg) Dose:_____ Daily as Needed

_____ Antacid/Calcium Tabs (Tums, 500 mg tabs) Dose: _____ Daily as Needed

_____ Throat lozenges/cough drops as needed for sore throat or cough

Allergies to any Medication_____ Current Medications: _____

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District 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 pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors to my child when there is a good faith belief that my child is having an anaphylactic reaction whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 98-795). I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and

I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

_____

Parent/Guardian Signature Date

_____

Physician/Licensed Healthcare Provider Signature Date