

**School Medication Authorization Form
Parent Authorization**

Student's Name

Birth Date

Class

Medication Allergies

I, the parent/guardian of _____, a student at Pinckneyville Community High School District #101, hereby acknowledge that I am primarily responsible for administering medication to my child. However, during school hours when I am unable to administer or in the event of an emergency, I hereby authorize Pinckneyville Community High School District 101 and its employees, on my behalf, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of the school district), the following named non-prescription medication following manufacturer's guidelines or prescription medication as ordered physician.

Please check which medications may be administered.

<input type="checkbox"/> Ibuprofen (Advil) 200mg (1-2 tabs)	<input type="checkbox"/> Calamine lotion
<input type="checkbox"/> Acetaminophen (Tylenol) 325 mg (1-2 tabs)	<input type="checkbox"/> Triple antibiotic ointment
<input type="checkbox"/> Naproxen Sodium (Aleve) 220mg	<input type="checkbox"/> Burn gel (Lidocaine HCL – 2.0%)
<input type="checkbox"/> Antacids (Tums or Rolaids) (2-4 tabs)	<input type="checkbox"/> Cough drops
<input type="checkbox"/> Prescription Medication as ordered by physician _____	

I acknowledge that medication will be administered by or under the supervision of the school nurse, parent or administrative staff, and specifically consent to such practices. I further acknowledge and agree that, when the medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and School Board/Administration arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and School Board /Administration, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

I have read, understand and agree to the regulations concerning administration of medication at school. I agree to the release of health information between the school nurse and physician.

Parent/Guardian Signature

Home Phone

Parent/Guardian Address

Business/ Emergency Phone

Name of Physician

Physician Phone

Date

STUDENT: _____ **MEDICATION LOG / YEAR** _____
BIRTH DATE: _____ **GRADE:** _____ **COMMENTS:** _____
MEDICATION: A - Ibuprofen 200mg i-ii q 4-6 hr. N - Naproxen Sodium 220mg i q 8-12 hr. M - Antacid 2 to 4 tabs q 1 hr.
T - Acetaminophen 650 mg ii q 4-6 hr. P - Acetaminophen-Caffeine-Pyridamine Maleate 2 tabs q 4-6 hr.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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INITIALS: _____ **NAME:** _____ **INITIALS:** _____ **NAME:** _____
Please put the medication code and time in the appropriate box. Nurse administering the medication is to initial the box.
*Student initials designate that no medications were taken within the past 4 hours and current dose was received