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.

___ Ibuprofen (Advil) 200mg
___ Acetaminophen (Tylenol) 325 mg
___ Naproxen Sodium (Aleve) 220mg
___ Antacids (Tums or Rolaids)
___ Calamine lotion
___ Triple antibiotic ointment
___ Burn gel (Lidocaine HCL – 2.0%)
___ Cough drops
___ 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 _____

5/2017

MEDICATION LOG / YEAR_____

STUDENT:_____ Birth Date:_____Grade: _____ COMMENTS : _____

MEDICATION: A- Ibuprofen 200 mg i-ii
T- Acetaminophen 325 mg i-ii q 4-6 hr
N- Naproxen Sodium 220 mg 1 q 8-12
M- Antacid 2-4 tabs q 1h

	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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MAY																															

INITIALS: _____ NAME: _____ INITIALS: _____ NAME: _____

INITIALS: _____ NAME: _____ INITIALS: _____ NAME: _____

Please put the medication code, and your nurse initials in the appropriate box.
** Student initials designate that no medications were taken in the past 4-8 hours and current dose as noted was received