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