Authorization to Administer Medication

Student Name: _____ Grade: _____ DOB: _____

***Medical Provider Section**

Medication Allergies: _____ Other Allergies: _____

Known condition(s)/ diagnosis(es): _____

Medication:	Dose:	Route:	Time to be given at school:	Time to be given at home	Purpose of Medication

Medical Provider, over-the-counter medications listed below are available at the school.
Please indicate if the school staff may administer OTC medication to this child/student, and the dose and frequency.

Oral Medication(s)

Acetaminophen 500mg tablet for c/o pain or to reduce fever less than 101	**YES**	**NO**	**_____Tablets**	**Every _____Hours**
Acetaminophen 80mg chewable tablet for c/o pain or to reduce fever less than 101	**YES**	**NO**	**_____Tablets**	**Every _____Hours**
Cough Drops (menthol/cherry or lemon flavored) for c/o sore throat or cough	**YES**	**NO**	**_____Tablets**	**Every _____Hours**
Tums 750mg antacid chewable tablet for c/o heartburn, indigestion, or sour stomach	**YES**	**NO**	**_____Tablets**	**Every _____Hours**

Topical Medication(s)/ application(s):

Triple Antibiotic Ointment applied to minor cuts/abrasions after cleaning with soap/water, cover with bandage	**YES**	**NO**
Sunscreen, broad-spectrum/SPF 30 applied to unbroken skin that is exposed to the sun	**YES**	**NO**

Medical Provider Signature: _____ **Date:** _____

Medical Provider print/stamp name, address, phone, fax:

****PARENT SECTION: REQUEST THAT SCHOOL ADMINISTER MEDICATION***

- I understand that my child attending Hanover School District Schools does not self-carry or self-administer medication(s) without specific authorization for specific medications..
- I request and authorize that the medication(s) listed above be administered to my child by qualified school personnel in the manner specified as authorized by the medical provider.
- I understand that it is my responsibility to furnish the prescription medication to the school in its original pharmacy container with the current labeling of medication, dose, frequency, **any written instructions from the manufacturer or the student's physician regarding potential side effects,** and child's name. NO EXPIRED MEDICATIONS ACCEPTED.
- I understand that if my child requires prescribed emergency medication the medication is available to him/her when needed.
- I will notify the school immediately if the medication is to be changed or terminated or if we change physicians.
- It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian.
- In consideration of the acceptance of the request to perform this service by the school nurse, or other designated employee, the undersigned parent or guardian, hereby agrees to release Hanover School District No. 28 and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I hereby give permission for my child to take the above name prescription medication and/or OTC medication at school as prescribed.

_____ _____

Parent/Guardian Printed Name Phone Number

_____ _____

Parent/Guardian Signature Date

My Child is enrolled in: **Medicaid** **CHP+** **Insurance** **No Insurance**

I would like information about CHP+/Medicaid: **Yes** **No**

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