AUTHORIZATION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION

District policy states that medication may be given to students only upon the written request of the student's physician and parent. Tylenol, ibuprofen and antacid, in the indicated dosages below, will continue to be supplied by the school and will be administered to students who have provided us with written permission from their physician and parent/guardian.

This form must be completed and returned to the school nurse before the medication can be administered. This form is good for the current school year only. A new form must be completed and signed each school year.

TO BE COMPLETED BY THE DOCTOR:

Student's Name: _____ ID#_____

Diagnosis: ____Headache/ Muscle pain/ stomachache

The following over-the-counter medications are available in the health services office in the indicated dosages.
Please check the appropriate box(es) for the medications the student may receive as needed.

☐ **Tylenol (650 mg orally every 4-6 hours as needed)**

☐ **Ibuprofen (400 mg orally every 6 hours as needed)**

☐ **Antacid (2 tablets every 4 hours as needed)**

Special instructions: _____

Other medications student is receiving: _____

I request that the school nurse administer the above medication. Permission is also given for the nurse to contact the authorized prescriber as needed. I understand that in the nurse's absence, the student may be allowed to self-medicate under staff supervision.

District 211 along with its employees shall incur no liability (except for willful and wanton conduct) as a result of injury arising from the student's self-administration of medication. The parent/guardian also indemnifies and holds harmless District 211 and its employees against any claim (except a claim based upon willful and wanton conduct).

_____ _____

Physician's Signature Date **Parent/Guardian's Signature** Date

_____ _____

Print Name Relationship

_____

Phone Number

PALATINE HIGH SCHOOL NURSE FAX NUMBER: 847-755-1861