Parental Authorization

For the Administration of Medication

Student's Name | Birth Date | Grade

Medication Allergies

I, the parent/guardian of_____, a student at Sparta CUSD #140 ., hereby acknowledge that I am primarily responsible for administering medication to my child. However, during school hour when I am unable to administer or in the event of an emergency, I hereby authorize Sparta CUSD #140 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 (Motrin) Age Appropriate

___ Acetaminophen (Tylenol) Age Appropriate

___ Naproxen Sodium (Aleve) Age Appropriate

___Antacids (Tums or Rolaids)

___Prescription Medications as ordered by Physician_____

___ Benadryl Cream

___ Triple Antibiotic ointment

___ Burn gel (Lidocaine HCL 2.0%)

___ Cough drops

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, 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 and physician.

Parent/Guardian Signature | Home phone

Parent/Guardian Address | Business/Emergency Phone

Name of Physician | Physician Phone

Date | Physician Signature