Rankin District #98 **Over the Counter Medication Authorization Form** **2022-2023**

Students Name:_____ Birth Date:_____Grade:_____

Illinois State Law requires a written medical authorization by a Health Care Provider (physician, nurse practitioner, PA, etc.) as well as written consent from a parent/guardian in order for the nurse, or in her absence, designated staff, to provide first aid and/or administer over-the-counter medication for minor medical needs. This does include medications such as ibuprofen, acetaminophen, cough drops, triple antibiotic ointment, etc.

Following Medicines to be provided by parent/guardian

☐ Medication: Tylenol/Acetaminophen

Dosage: _____ Frequency: _____

☐ Medication: Ibuprofen

Dosage: _____ Frequency: _____

Frequency: _____

☐ Medication: _____

Dosage: _____ Frequency: _____

☐ Medication: _____

Dosage: _____ Frequency: _____

Please check all treatments below that you approve for First Aid Care for your student

For minor cuts/abrasions/insect stings/burns/toothache/muscle aches the following may be applied:

_____ Triple Antibiotic Ointment
_____ Hydrocortisone 1% Cream
_____ Burn Free Pain Relieving Gel
_____ Aloe Vera gel
_____ Orajel
_____ Muscle Rub Cream
_____ Caladryl Lotion
_____ Sterile eye drops
_____ Cough drops
_____ Other _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must provide all medication in the original bottle with the student's first and last name written on the bottle. I understand that medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first. I also understand that my signature allows for verbal communication as necessary between the school nurse and the above prescriber to ensure safe administration of all medication marked above.

_____

PARENT/GUARDIAN PRINTED NAME **PARENT/GUARDIAN SIGNATURE** DATE

Physician's Signature: _____ Physician's Name (please print): _____

Physician's Address:

_____

Physician's Phone: _____ Date: _____