Black Hawk School District Non Prescription Medication Administration Authorization

STUDENT NAME ________________________

(Per policy, MD or licensed prescriber signature required for prescriptions. Guardian signature required for both prescription and over the counter medications. Must be completed each school year)

Qualified persons trained in medication administration have my permission to administer the following medications *as directed on the label*

(You do NOT have to supply the medication)

Please initial each medication you give permission to administer at school:

________ Ibuprofen (check one: Liquid______ Tablets ______)

***For pain, fever**

________ Tylenol (check one: Liquid______ Tablets______)

***For pain, fever**

________ Benadryl (Check one: Liquid ______ Tablets ______)

***For Allergic reaction, itching**

________ Tums (Regular Strength)

Prescription medications to be taken at school: (Requires MD order and signature)

Medication	Dose	Route	Frequency	Self Carry?

Guardian signature _________________________________date________________

Printed guardian name ____

DATE	TIME	MEDICINE	DOSE	REASON