NAALEH
HIGH SCHOOL FOR GIRLS

Medication Administration Form

AUTHORIZATION TO GIVE OVER THE COUNTER MEDICATIONS IN SCHOOL

To dispense over the counter medications to your child, this form must be filled out and signed by both the *parent* and the *physician*.

I authorize the School Nurse, or another school employee trained by the nurse, to administer the following medication to my child during school hours or at any school event. I understand that the district, school, school nurse, and other school employees shall incur no liability as a result of any injury arising from administration of the medication; that I will indemnify and hold harmless the district, school, school nurse, or other school employees against any claims arising from the administration to my child.

Acetaminophen 650mg for pain or fever by mouth- may repeat every 4 hours	☐ YES	☐ NO
Ibuprofen 400mg for pain by mouth- may repeat every 6 hours	☐ YES	☐ NO
Benadryl 25mg-50mg by mouth- acute allergic reactions	☐ YES	☐ NO
Tums 1-2 Tablets as needed for indigestion	☐ YES	☐ NO
Cough Drops Lozenge as needed for cough/sore throat	☐ YES	☐ NO
Opti-clear eye drops for itchy, red eyes	☐ YES	☐ NO

Student Name _____ Student Grade _____

Parent Name _____ Parent Signature _____

Physician Name _____ Physician's Signature _____

Date _____

☐ **If you do not wish to allow for medication administration by school nurse or employee, please check this box.**