EVANSVILLE DAY SCHOOL
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AUTHORIZATION FOR ADMINISTERING MEDICATION BY SCHOOL PERSONNEL

Name of Student:_____ **Grade**___ **DRUG ALLERGIES:**_____

Medical Conditions:_____

The following medications are kept "in stock" for your convenience. Recommended directions on the bottle/container will be followed.

- **Tylenol (headaches/pains)**
- **Ibuprofen (headaches/pains)**
- **Advil (headaches/pains)**
- **Tums (stomach aches/pains)**
- **Pepto Bismol (stomach aches/pains)**
- **Benadryl (allergy symptoms)**
- **Antihistamine/Hydrocortisone Cream (itchiness/minor rash/bug bites)**
- **Aloe Vera (minor burns)**
- **Neosporin (minor cuts/scrapes)**
- **Cough drops (cough/sore throat)**
- **Other common medications as needed**

***Please check one of the following:**

____ I approve <u>all</u> of the above
____ I approve <u>none</u> of the above
____ I approve all of the above <u>except</u> those marked with an "X":

I release and agree to defend, indemnify, and hold harmless Evansville Day School, its employees, and its agents from any and all loss, liability, costs, attorney fees, or claims (including claims of the student) arising from or related to the administering of the medication(s) listed above.

_____ _____ _____
Signature of Parent/Guardian **Contact Phone#** **Date**

*Visits to the nurse's office requiring any treatment will be emailed to the primary contact.
**<u>This form will be carried over yearly</u> until the student enters the next division. If any changes occur it is the parent/guardian's responsibility to inform the school nurse:
nurse@evansvilledayschool.org

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PRESCRIPTION MEDICATION FORM

I authorize school personnel to administer to the student the prescription medication listed below (please complete a separate form for each medication):

Prescription Medication:_____
Prescribing Doctor:_____
Dosage Required:_____
Dates and Time to Administer (PRN if "as needed"):_____
Additional Directions:_____

I release and agree to defend, indemnify, and hold harmless Evansville Day School, its employees, and its agents from any and all loss, liability, costs, attorney fees, or claims (including claims of the student) arising from or related to the administering of the prescription medication listed above.

_____ _____ _____
Signature of Parent/Guardian **Contact Phone#** **Date**

I authorize school personnel to administer to the student the prescription medication listed below (please complete a separate form for each medication):

Prescription Medication:_____
Prescribing Doctor:_____
Dosage Required:_____
Dates and Time to Administer (PRN if "as needed"):_____
Additional Directions:_____

I release and agree to defend, indemnify, and hold harmless Evansville Day School, its employees, and its agents from any and all loss, liability, costs, attorney fees, or claims (including claims of the student) arising from or related to the administering of the prescription medication listed above.

_____ _____ _____
Signature of Parent/Guardian **Contact Phone#** **Date**

*All visits to the nurse's office requiring any treatment will be emailed to the primary contact.
**This form will be carried over yearly until the student enters the next division. If any changes occur it is the parent/guardian's responsibility to inform the school nurse:
nurse@evansvilledayschool.org