Student's name____ Grade__________
Date of birth____

NASHVILLE COMMUNITY HIGH SCHOOL DIST. #99
Medication Authorization Form

This form must be completed and signed by both parent AND primary healthcare provider (MD, DO, PA-C, NP) and turned into the school before NCHS nursing office staff will store or dispense any medication for your student.

I give the school nurse permission to administer as needed:

Acetaminophen (Tylenol) 1-2-325mg tablets	yes	no	Triple antibiotic ointment	yes	no
Ibuprofen (Advil/Motrin) 1-2 200mg tablets	yes	no	Benadryl Topical	yes	no
Antacid tablets (Tums) 2-4 tablets	yes	no	Cough drops	Yes	no

Nurse's office supply

My student has a valid prescription of the following medication. I allow the school nurse or other NCHS employee, if needed, to administer medication following the prescribed guidelines. NCHS has my permission to contact the medical provider to verify this medication authorization. Medication should be brought to school nurse for storage.

Medication	Dosage	Route	Frequency	Time to be given at school	Indication for medication

Permission to carry (Epinephrine pen or insulin)

My student may carry and use the following medication as needed for symptoms prescribed by our medical provider during the school day. My student has been properly instructed in the use and self-administration of this medication. NCHS has my permission to contact the medical provider to verify this medication authorization.

Medication	Dosage	Route	Frequency	Time to be given at school	Indication for medication

- I hereby authorize NCHS and its employees or agents to allow my student to administer lawfully this over-the-counter or prescribed medication in the manner indicated.
- I understand that it may be necessary for the administration of the above medications to my student to be performed by a willing school employee other than the school nurse, and specifically consent to such practices.
- I agree to indemnify and hold harmless the school district and its employees and agents against any claims, except in a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student.

__________________________________ __________________________ ______________
Parent/Guardian signature Phone Date

__________________________________ __________________________ _______________
Primary Healthcare Provider's signature Phone Date