

## School Medication Authorization Form

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### **Permission for Tylenol and Advil:**

*In the event that your child has minor aches or pain, we will give them the following medications that you authorize.*

Please check off your choices. The office keeps a supply of these medications.

\_\_\_ Tylenol 1-2 tabs    \_\_\_ Advil 1-2 tabs    \_\_\_ Children's liquid Tylenol

\_\_\_ Do not give my child Tylenol or advil

### **Permission for the administration of medications to treat allergic reaction:**

My child is allergic to: \_\_\_\_\_

Allergic reaction to above is: \_\_\_\_\_

I hereby grant Lubavitch Hebrew School and its staff permission to administer the following medications in the event of a medical emergency:

I allow Lubavitch Hebrew School and its staff to use an Epi Pen in the event of an allergic reaction.

Epi Pen instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I allow Lubavitch Hebrew School and its staff to administer Benadryl in the following doses should my child experience an allergic reaction:

Benadryl instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By signing below, I agree:

1. That I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Lubavitch Hebrew School and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of Lubavitch Hebrew School), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices, and
2. To indemnify and hold harmless Lubavitch Hebrew School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

Parent's Name: \_\_\_\_\_

Parent's/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_