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Cowden-Herrick CUSD 3A

2018-2019 Medicine Registration and Administration Form

Student's name: _____ Birthdate: _____

This form must be completed before Cowden-Herrick Jr/Sr High School will administer prescription drugs or over the counter medication. Please complete the applicable medical section and the signature section at the bottom of the page.

<u>OVER THE COUNTER MEDICATIONS:</u> (The office will provide Ibuprofen. All other medication must be provided by the student). Please check if you authorize the school to administer two 200mg Ibuprofen tablets every 4 to 6 hours for minor aches and pains. _____

Name of medication: _____

Dosage to be given: _____

Time medication should be administered (ex: morning, noon, as needed) _____

Illinois or condition being treated: _____

<u>PRESCRIPTION DRUG:</u>

Name of medication: _____

Dosage to be given: _____

Time medication should be administered (ex: morning, noon, as needed) _____

Illness or condition being treated: _____

Route of administration if not by mouth: _____

Date of prescription (if applicable):_____

Physician's name: _____

Parent/Guardian signature _____

Parent/Guardian phone number: _____