

ADDLEBY GRADE SCHOOL DISTRICT #15

Medication Authorization Form 2026-2027 School Year

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 AGS WILL STORE OR DISPENSE ANY MEDICATION FOR YOUR STUDENT.

I give the school permission to administer to my child, _____, as needed:

Acetaminophen (Tylenol) 2-500mg tablets	yes	no	Triple Antibiotic ointment	yes	no
Ibuprofen (Advil/Motrin) 1-2 200mg tablets	yes	no	Benadryl Topical	yes	no
Children's Ibuprofen (Chewable) 1-3 100mgs	yes	no	Vaseline	yes	no
Children's Tylenol (Chewable) 2-6 80mgs	yes	no	Cough Drops	yes	no
Children's Tylenol (Syrup) 1-2 tsp 160mgs	yes	no	Tums 2-4 tablets	yes	no
Children's Ibuprofen (Syrup) 1-2 tsp 100mgs	yes	no	Lip Balm	yes	no
Orajel	yes	no			

Personal Supply

My student has a valid prescription of the following medication and I allow AGS School Personnel if needed to administer following the prescribed guidelines. AGS has my permission to contact the medical provider to verify this medication authorization.

Medication	Dosage	Route	Frequency	Time to be Given @ School	Indication for Medication

- I hereby authorize AGS and its employees or agents 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, 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 administration of medication to the student.

Parent/Guardian Signature

Phone

Date

Primary Healthcare Provider's Signature

Phone

Date

