Walsh Academy
6935 West Touhy Avenue, Niles, IL 60714
P: (847) 390-3020
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Medication Administration Authorization for Non-Prescription Medications

(2023 – 2024)

Student Name **Birthdate**

I, as the parent/guardian of the above identified student, authorize by my signature below Walsh Academy's nurse and/or administrators to monitor administration of medication to my student of the below identified non-prescription (over-the-counter) medication. Furthermore, I understand my responsibilities to and authorize any/all of the following:

- Parent/guardian will provide any/all medication listed below and do so in accordance with the Walsh Academy's "Medication Administration Policy".
- Release Walsh Academy faculty from any liability in relation to this authorization when medication is administered in accordance with the information provided below.
- Permit School Nurse to communicate with any/all Walsh Academy faculty about side effects relevant to the below identified medication(s).
- Permit School Nurse to consult with the below identified Attending Physician regarding any questions pertaining to any/all medication identified below, including consultation regarding the medical condition being treated.
- Permit School Nurse to obtain the below identified physician's signature via fax when necessary.

Over-the-Counter / Non-Prescription Medication

Medication Name	Dosage	Time	Administration Instructions
Tylenol			
Ibuprofen			

Please note that all of the above items are considered medications under new ISBE guidelines. Physician Authorization is REQUIRED for any of the above medications to be given at school. Without a Physician's Authorization, the above medications will NOT be allowed to be administered at school, even if a parent has signed the form. If your student is to receive any of the above medications at school, a new, unopened container must be brought to the school for your student's use only.

Attending Physician Authorization

Physician Name (Print) | Street Address 1 | Phone 1

Practice / Clinic Name | Street Address 2 | Phone 2

Physician Signature | Date | City, State, Zip Code | Fax

Parent / Guardian (Print Name) **Signature** **Date**

This consent is mandatory for student enrollment. Failure to fully complete and sign this consent will prevent the above named student from being enrolled at the Walsh Academy. This consent is valid until one (1) year after above date of parent/guardian signature.