LICK CREEK CCSD #16

2025 - 2026 MEDICATION AUTHORIZATION FORM

Student's Name _____ **Grade** _____

Date of Birth _____ **Age** _____

Parent(s) Preferred Phone _____ **Alternate Phone** _____

I give authorization for Lick Creek CCSD #16 personnel to give the above student the following medications for short-term use during school hours:

- ☐ Ibuprofen - 200 mg. (Advil) _____ (# of tablets every 4-6 hrs. No more than 8 in 24 hrs.)
- ☐ Acetaminophen-500 mg. (Tylenol) _____ (# of tablets every 4-6 hrs. No more than 8 in 24 hrs.)
- ☐ Antacids (Tums, Pepto Chewable)

Allergies _____

Other medication as specified:

***(Medication must be brought to school by the parent/guardian in the original container with appropriate label(s) intact. If medication is not properly labeled, it will not be given.)**

Name of medication _____ **Dosage** _____

Time(s) medication should be given _____

Special instructions:

_____

_____

I hereby authorize Lick Creek School District #16 and its employees on my behalf and stead, to administer or to attempt to administer to my child lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a School Nurse or Health Aide, and specifically consent to such practices. I further acknowledge, and agree that, when lawfully prescribed medication is administered, I waive any claims I might have against Lick Creek School District #16 and employees arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Lick Creek School District #16 and its employees, either jointly or severally, from incurred or resulting from the administration or attempts at administration of said medication.

Parent/Guardian Printed Name _____ **Date** _____

Parent/Guardian Signature _____