MEDICATION AND ALLERGY

Occasionally students will request or require medication while under our supervision. State law allows us to comply with this request if WRITTEN PERMISSION is provided by the parent/guardian.

Child's Full Name: _____ Date: _____

PERMISSION TO DISPENSE MEDICATION AND ADMINISTER FIRST AID

☐ I **DO AUTHORIZE** the school nurse or her designee to administer the following medication(s) to my child

☐ Acetaminophen (generic Tylenol) Dosage: _____

☐ Antihistamine (generic Benadryl) Dosage: _____

☐ Ibuprofen (generic Motrin) Dosage: _____

☐ Antiseptic Wash for cleaning wounds

☐ Antibiotic Ointment for bandaging wounds

Additional Medications to be administered at School: Medications must be in the original container with student's name, name of medication, directions for administration, date and healthcare provider's name and signature. The signature can be on a separate note (such as a prescription) but it must accompany the medication and include the child's name, date and medication on it. Medications will be locked in the office and will be administered as prescribed.

Name of Medication	Dosage and Route	Time/Frequency
_____	_____	_____
_____	_____	_____

I give permission for the staff to assist my child by providing over the counter medication if indicated above and to assist with the prescription medication listed above. By signing this form I agree that I will not hold the staff responsible for any adverse reactions from the medication.

PARENT SIGNATURE: _____ DATE: _____

KNOWN ALLERGY INFORMATION

Please indicate in detail all known allergies. If no allergies, please select NO KNOWN ALLERGIES.

☐ My child has **NO KNOWN ALLERGIES**

☐ My child has the following allergies:

☐ Food - _____

☐ Environment - _____

☐ Medication - _____

☐ Other - _____

PARENT SIGNATURE: _____ DATE: _____