# RETURN TO SCHOOL

**STUDENTS 09.2241 AP.21**

**Permission Form for Non-Prescribed and Prescribed Medication**

I/We, ,arthparent(s) of \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Who is

Parent /Guard ia n Name(s) years of age and is in the

Student' s Name

grade at school.

I/ We understand there are times my child may have a headache, upset stomach, sore throat, small cuts, bug bites , pain from a sma ll injury, a small temperature no greater than I00, etc. Upon reviewing the medications listed below, I/We have checked the medications

' which may be administered to my child while at school. (If you DO NOT want your child to be given medicine or medical attentio n, please check lines under NO. Please indicate any known allergies here:

**Medications\***

Over-the-counter medicine for pain/fever/headache relief (Example: Tylenol, Motrin , Ibuprofen) Anti-diarrhea - Anti-nausea liquid or chewable (for upset stomach, ind igest ion, diarrhea , heartburn or nausea)

Sore throat lozenges (for sore throats, and coughing) Antacid (Tums/ Rolaids, etc.) (for indigestion or heartburn)

Cala mine lotio n/ant ise ptic creams and sprays (for bug bites and cuts) Band-Aid (protection for cuts, bliste rs, etc.)

Benadryl - Allergy - insect bites /sti ngs etc.

Over-the-counter cold medicine (Tria minic, Di metapp, Sudafed or generic equivalent) Self-Administration of Asthma Medication (Requires Physicia n Signature Below) Other: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**YES NO**

I further give my permiss ion to administer medication that I/ we have sent to school whether it is an over-the-co unter d rug(s) or prescription drug(s) prescribed by the child ' s medical doctor.

(ALL PRESCRIPTION DRUGS MUST BE IN THEIR **ORIGINAL PRESCRIPTION BOTTLE** WITH PRESCRIPTION LABEL STILL DISPLAYED ON THE BOTTLE. IF A PRESCRIPTION DRUG IS SENT TO SCHOOL WITH YOUR CHILD BE SURE HE /SHE BRINGS IT TO THE OFFICE UPON ARRIVAL TO SCHOOL. SCHOOL PERSONNEL WILL CALL PHYSICIAN AND/OR PARENT(S) FOR INFORMATION AS NEEDED.)

# STUDENTS 09.2241 AP.21

I/We give permission for to receive medications at school according

Student' s Name

to standard school policy and expressly hold harmless and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of medication unless such is the result of negligence or misconduct on behalfofthe school or its employees.

If both parents or guardians are living in your house hold, BOTH signatures are required.

\_\_\_\_\_\_\_\_\_\_\_\_ / \_ and  / \_\_\_\_\_

**Parent/Guardian Signature Date**

**Parent/Gua rdian Signature**

**Date**

List any telephone numbers that will he lp us to locate you in case of an EMERGENCY. Home: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Work: \_

Other: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Other: \_

**S ELF- A DMINIST RATI ON OF ASTHM A M EDICATION:**

Requires Annual Physician' s Signature: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

\*A medication log will be kept. If your child 's sy mptoms continue for more than three (3) consecutive days, you will be contacted . For student health services/procedures not involving medication only, please refer to 09.22 AP.22.

Reviewed/Revised 6/22/2011

58