THE Wyndcroft SCHOOL

Medication Permission Form 2018-2019

Student Name_____ **Grade** _____

The school nurse is permitted to give medication to your child only with signed permission from your child's physician. If you want your child to receive any prescription or non-prescription medications **during school hours or on field trips**, please complete this form, **signed by a physician** and return it to school. A new form must be filled out each year.

Non-Prescription Medications: The following over-the-counter medications are provided by the school: Acetaminophen, ibuprofen, cough drops and Rolaids, **but only with a physician's signature.** If other medication is necessary, for instance occasional cold medicine, please list it below and supply it to the nurse. **We will accept a faxed note or script from the MD.** Please know that the school nurse will always try to contact a Parent / Guardian when it is necessary to administer medication.

Over-the-counter

Medication	Check	Dose (please specify) as directed on medication
Aspirin/Tylenol/Motrin/Advil		
Benadryl		
Non-pseudo Decongestant		
Rolaids/Tums		
Eye Drops		
Antibiotic Ointment		
Chloroseptic Spray		
Seasonal Allergy Medication		

Prescription Medications:

Name of Medication	Dosage	Date to be given	Time to be given
Name of Medication	Dosage	Date to be given	Time to be given

Reason for medication:
_____

PHYSICIAN SIGNATURE: The above-named student has permission to receive medications as listed above at school or on field trips:
Physician's Name (please print) _____
Telephone_____

Physician's Signature_____
Date _____

PARENT CONSENT: My child has permission to receive medications as listed above at school or on field trips.

Parent/Guardian Signature _____
Date_____

☐ My child has permission to carry an inhaler/Epi-pen to school or sports and to self-medicate. (check if applicable)

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