CINCINNATI HILLS CHRISTIAN ACADEMY (2020-2021)
School Medication Permission Form **– Preschool Students Only**
(For both Over the Counter and Prescription Medications)

In accordance with Ohio Revised Code 3313.713 and our School Medication Policy (found in the Family Information Guide), a parent/guardian consent **and** doctor/dentist consent is required for **all** medications to be given to a student by school personnel. **This includes over-the-counter medication.** All requested information must be completed in full, including **physician's signature** and returned to the health room.

This area to be completed <u>in full by the parent / guardian</u>

Name of Student_____ Date of Birth_____ Grade_____

Student's Address_____ CHCA Building_____ Home Room_____

I authorize a Cincinnati Hills Christian Academy nurse or school personnel to administer medication as instructed to my child. I agree to deliver the medication in a timely manner to the school in the original container with pharmacy label if applicable. I will notify the school if I change physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. I fully release Cincinnati Hills Christian Academy, its employees and Board of Trustees from all liability related to the administration of this medicine.

Parent/Guardian Signature_____ Printed Name _____Date_____

Phone during school hours: #1_____ #2_____
Circle one: Home / Work / Cell Circle one: Home / Work / Cell

Parent/Guardian Signature_____ Printed Name _____ Date_____

Phone during school hours: #1_____ #2_____
Circle one: Home / Work / Cell Circle one: Home / Work / Cell

This box to be completed <u>in full by the physician:</u>

<u>NOTE</u>: If dose not indicated below for Over the Counter Medications, will follow manufacturer's recommended dosage for age/weight.

Date of Authorization_____ Start Date _____ Stop Date _____

- ❑ Acetaminophen Junior (ie. Tylenol Jr.- Q4 to 6 hours PRN-Oral): _____mg
- ❑ Ibuprofen Junior (ie. Motrin Jr. or Advil Jr. – Q 6 to 8 hours PRN-Oral): _____ mg
- ❑ Other Medication:_____ Dosage / Route_____

Time(s) to be given:_____ Frequency_____

<u>First aid items:</u>

- ❑ Triple antibiotic ointment for minor wounds
- ❑ Hydrocortisone cream (1%) for itching
- ❑ Cough drops - 1 drop q2h
- ❑ Caladryl Clear for itching from insect bites, rashes

<u>Allergies:</u> for orders related to specific symptoms submit an Allergy Action plan found on the CHCA website.

- ❑ Diphenhydramine HCL (ie Benadryl) - _____ mg oral route, Q_____hours for minor allergic reactions
- ❑ Epinephrine _____ mg, IM, into outer thigh and call 911 for emergency treatment of severe, life threatening allergic reaction
- ❑ Asthma Inhaler_____- _____puffs Q_____ prn for wheezing, shortness of breath, cough

Adverse reactions to be reported for any listed medication _____

Special instructions: _____

Procedure to follow in the event medication does not relieve symptoms: _____

Prescribing physician (print) _____ **Signature**_____

Physician emergency telephone_____ Alternate phone #_____ Fax #_____

<u>THIS PERMISSION FORM IS NO LONGER VALID AFTER THE END OF THE CURRENT SCHOOL YEAR</u>

(REV. 3-30-20 SJL)

Created on 6/1/2020