



Medical Information and Consent to Dispense Medications—SY2016/2017

Student's Name (Please Print): _____ Birthdate: _____

Grade for the 2016/2017 School Year: _____ Known Allergies: _____

List All Medical Concerns: _____

School Provided Non-Prescription Medications

The school nurse/office may dispense the following medications to my child **(check all that apply)**:

Advil (100mg/5ml or 200 mg/tablet)

- 1 ½ tsp or 7.5 ml (4-5 yr old/36-47 lbs)
- 2 tsp or 10 ml (6-8 yr old/48-59 lbs)
- 2 ½ tsp or 12.5 ml (9-10 yr old/60-71 lbs)
- 3 tsp or 15 ml (11+ yr old/72-95 lbs)
- 1 Tablet
- 2 Tablets

Tylenol (160mg/5ml or 325mg/tablet)

- 1 ½ tsp or 7.5 ml (4-5 yr old/36-47 lbs)
- 2 tsp or 10 ml (6-8 yr old/48-59 lbs)
- 2 ½ tsp or 12.5 ml (9-10 yr old/60-71 lbs)
- 3 tsp or 15 ml (11+ yr old/72-95 lbs)
- 1 Tablet
- 2 Tablets

Benadryl (12.5mg/5ml or 25mg/tablet)

- ½ tsp or 2.5 ml (2-5 yr old)
- 1 tsp or 5 ml (6-11 yr old)
- 2 tsp or 10 ml (6-11 yr old)
- 1 Tablet
- 2 Tablets

- Antacid (TUMS)
- Cough drops
- Saline eye drops
- Hydrocortisone cream 1% (May apply no more than every 6 hours for itching.)
- Antibiotic ointment/Neosporin (May apply no more than every 8 hours for the prevention of infection in minor cuts, scrapes, or burns.)
- DO NOT DISPENSE ANY MEDICATION TO MY CHILD.**

Parent Provided Over-the-Counter Medications – These are to be furnished by the parent, in the original container with the student's name and dosage instructions provided. Medications to be administered more than 10 days must have a physician's order. Medications not picked-up within 10 days will be disposed of in accordance to federal guidelines. Expired medication or medications without proper dosage instructions **will not** be administered to student.

Name of Medication	Route (by mouth, etc.)	Dosage	Time	Possible Side Effects

Parent Provided Prescription Medications – **All** medications must be furnished by the parent in the original container with affixed prescription label. No more than a 30 day supply of medication should be brought to the health office. All controlled substances should be brought in to the health office by a parent/guardian.

Name of Medication	Route (by mouth, etc.)	Dosage	Time	Expected Duration	Prescriber's Name	Indication for treatment	Possible Side Effects

Special Requirements (example: take with food): _____

Note: The very first dose of medications may not be given at school.

Health Care Provider Name: _____ Phone number: _____

I hereby authorize any hospital/doctor/EMS personnel to render immediate aid as might be required at the time for my child's health and safety. It is understood by me that the expense of this service will be accepted by me.

If possible, I request my child be transported to the following hospital: _____

***In case of emergency, please contact:** _____ **Phone number:** _____

By signing below I give my consent for the school nurse or other designated school staff to dispense the medications noted above to my child. I acknowledge that Archway Glendale personnel are not responsible for any ill effects which might occur.

Signature of Parent/Guardian: _____ Date: _____