PERMISSION FOR CHILD TO BE GIVEN MEDICATION AT SCHOOL BY SCHOOL PERSONNEL

This form is required for all students. Prescription medications require both a parent and a physician signature. Over-the-counter medications (see reverse side) require only a parent signature.

Child's Name: ____ Date:___________________

Allergies: ____

Name of Medication: ______________________________/Over-the-counter medications (see back)

Purpose of Medication: ____

Method of Administration: ____

Dosage: _________________________ Administration Time(s):_______________ am pm or As needed

Date from: _____________________________________ Date to:__________________________

Side Effects: ____

Special Instructions, if any: ____

* Signature if NO prescription medication____

* Signature if NO over-the-counter medication is allowed ______________________________

PARENT REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER PRESCRIPTION MEDICATION TO STUDENT

I hereby request that my child, ___________________________________ be given this prescription medication as prescribed by Dr. _________________________________ in this order. It is understood that Hawken School and any of its school personnel are absolved from any responsibility which might be associated with the administration of such medication.

______________________ ____________________________ __________________

Parent's Signature Parent's Daytime Phone No. Date

____________________________________ ____________________________________

Physician's Signature Physician's Phone No.

PLEASE RETURN FORM TO MRS. KARI GALI

Over-The-Counter Medications

Over-the counter medications listed below have been approved by a community pediatrician and are to be administered by the school nurse, Kari Gali, MSN, RN or her designee, as necessary. It is understood, that Hawken School and any of its school personnel are absolved from any responsibility which might be associated with the administration of such medication. This consent will be for the entire 2003-2004 academic year, unless otherwise specified.

Please initial all medications that you grant consent for administration to your child.

_____ (Motrin) Ibuprofen 200mg., 1-2 tablets for pain relief, every 4-6 hours, as needed.

_____(Tylenol) Acetaminophen 500mg., 1-2 capsules , for pain relief, every 4-6 hrs. as needed.

_____(Benadryl) Diphenhydramine 25mg., 1-2 caps, for allergic reaction, every 4-6hrs, as needed. **Students CAN NOT drive for 4-6 hours after receiving !

_____(Cortaid) Hydrocortisone cream 1% for rash/itching.

_____(Sudafed) Pseudoephedrine 30mg., 1-2tabs every 4-6 hrs., as needed.

_____(Rolaids) Calcium & magnesium antacid 1-2 chewable tabs. , every 4 hrs., as needed.

_____Menthol-eucalyptus cough drops, as needed.

_____Triple antibiotic ointment for topical administration.

Parent signature____