



# Christ the King School 2017-2018

## OVER THE COUNTER MEDICATION PERMISSION

\*Medication must be provided by the parent in the original, UNOPENED, container and labeled\*

Please check and indicate the dosage for the Over the Counter Medications provided.

- Tylenol/Acetaminophen:DOSE\_\_\_\_\_
   
Administered for: pain, fever, headache, menstrual discomfort
- Motrin/Ibuprofen:DOSE\_\_\_\_\_
   
Administered for: pain, fever, headache, menstrual discomfort
- Benadryl/Diphenhydramine HCL DOSE\_\_\_\_\_
   
Administered for itching, rash, allergies
- Topical medication name & DOSE\_\_\_\_\_
   
Administered for: cuts, scrapes, rashes
- Other-NAME & DOSE \_\_\_\_\_

My signature gives permission for Christ the King School to administer the over the counter medications indicated above.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Date

**FOR STUDENTS WHO TAKE PRESCRIPTION MEDICATION AT SCHOOL: FOR EXAMPLE, EPI-PENS, INHALERS, DAILY MEDS please fill out the form below.**

### Prescription Medication 2017-2018

Physician Name must be on label & in original container

Allergies to medication \_\_\_\_\_

Student Name & Grade \_\_\_\_\_ Date: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ Prescription number: \_\_\_\_\_

Medication name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route of administration: \_\_\_\_\_

Time: \_\_\_\_\_ Start date: \_\_\_\_\_ End date: \_\_\_\_\_

Physician's Name (must be on label): \_\_\_\_\_

Print/Signature: \_\_\_\_\_ Phone Number \_\_\_\_\_