Christ the King School 2020-2021

OVER THE COUNTER MEDICATION PERMISSION

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

STUDENTS NAME & GRADE_____

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 2020-2021

Physicians Name must be on the label & in the 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_____