

All Saints Episcopal School
Parent Request for Medication to be Administered at School as Needed

Student Name _____ Grade _____ Age _____ Weight _____

List any medication allergies _____

List all medication(s) student is currently taking: _____

- A copy of the Health Clinic Referral Slip will be sent home with the student indicating the name and time the medication was administered. (Please check your student's bag daily for any notes sent home.)
- I understand that my child, depending on their symptoms or injury, may still be required to be picked up from school.
- I will be notified of any side effects/reactions resulting from the medication administration and release All Saints School personnel from liability should any such reactions occur.
- My child will be instructed to return to the nurse if their symptoms do not resolve or if other symptoms develop.
- In the event the nurse is off campus, I understand that the medication may not be available for my child.
- This permission form will remain in effect for the current school year only, or until written notification is received from the parent/guardian.

Over-The-Counter Medications

Please initial next to the medication(s) you wish to be available for administration to your child at school.

_____ Pain/ Discomfort or Fever (Temperature greater than 100.0 °F): **Acetaminophen** (ex. Tylenol)
(May be administered for fever, but student must be picked up from school if they have temperature greater than 100.0° F.)
Acetaminophen will not be given for more than 2 doses per day for 3 consecutive days without written authorization from a physician and a parent signature.
Acetaminophen will be administered according to label directions, as needed.

_____ Pain/ Discomfort ,Inflammation or Fever (Temperature greater than 100.0 °F): **Ibuprofen** (ex. Advil or Motrin)
(May be administered for fever but student must be picked up from school if they have temperature greater than 100.0° F.)
Ibuprofen will not be given for more than 2 doses per day for 3 consecutive days without written authorization from a physician and a parent signature.
Ibuprofen will be administered according to label directions, as needed.

_____ Indigestion: **Mylanta**
Mylanta will not be given more than 2 doses per day for 3 consecutive days without written authorization from a physician and a parent signature.
Mylanta will be administered according to label directions, as needed.

_____ Indigestion: **Tums EX**
Tums will not be given more than 2 doses per day for 3 consecutive days without written authorization from a physician and a parent signature.
Tums will be administered according to label directions.

OR

_____ **I DO NOT WISH ANY MEDICATION TO BE AVAILABLE TO MY CHILD**

I give my permission for my Healthcare Provider and the School Nurse or the Headmaster of All Saints Episcopal School to share health care information as needed to provide safe and appropriate health care. This information may be shared with individuals working with All Saints Episcopal School for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

Parent/Guardian Name _____ Signature _____ Date _____