EAST PORTER COUNTY SCHOOL CORPORATION

MEDICATION ADMINISTRATION AT SCHOOL

Student's Name _____**Grade**_____**School Year** 2019-2020

My child may receive the medication(s) administered from the Nurse's Office. This is the only "in stock" medication available at your school.

____Generic **Tylenol**, **325mg or 500mg tablets**, given as needed per manufacturer recommendation:

Dose: per weight

The following medications/treatments may be given to your child when deemed necessary unless you specify otherwise: Hydrogen peroxide, Ethyl rubbing alcohol, antibiotic ointment, Calamine lotion, Sting relief, Bactine, Ora-Gel, hand/body lotion, cough drops (middle and high school), or hard candies to soothe cough/sore throats, Equate contact solution, and saline eye drops.

Other medication/Prescription or Over the Counter supplied by parent to be given at school:**

Medication:_____ **Dose**_____

When to give:_____

Reason for medication:_____

Medication_____ **Dose**_____

When to give:_____

Reason for medication:_____

If more than 2 medications, use back of this form

Permission to use/carry inhaler

My child has been instructed in the proper use of his/her_____inhaler.

_____Inhaler can be carried on person. (If carried on person, a written order from the physician is needed. The school nurse will be notified if the student will be carrying an inhaler at school. The school is not responsible for safeguarding the student's inhaler at school.)

_____Inhaler needs to remain in nurse's office

_____

***No medication, prescription or over-the counter will be given to a student without this or other written authorization from the Doctor and/or Parent/Guardian. The pharmacy label on the prescription bottle serves as written authorization by the Doctor, and this signed notice serves as

written authorization by the Parent/Guardian. All medication must be in its original bottle and clearly labeled. ***The nurse cannot dispense unidentified medication in a plastic bag or unmarked container.***

This authorization form is valid for the current school year only.

Parent/Guardian Signature_____Date_____

Other Medication/ Prescription or Over the Counter supplied by parent to be given at school:**

Medication: _____ Dose: _____

When to give: _____

Reason for medication: _____

Medication: _____ Dose: _____

When to give: _____

Reason for medication: _____

Medication: _____ Dose: _____

When to give: _____

Reason for medication: _____

Parent/Guardian Signature: _____ Date: _____