



The Seven Hills School – Middle/Upper Consent to Administer Medication at School

(School Guidelines For Administration Of Medication At School On Reverse Side)

In order for school personnel to **administer prescribed or over-the-counter drugs** such as Tylenol to a student, the following information **must be on file and contain the written consent of the licensed prescriber and parent.**

Name of Pupil _____ Date of Birth _____

Address _____ Zip Code _____

Phone _____ Division _____ Grade _____

Allergies _____ Special Needs and Conditions: _____

To be completed by the physician/licensed prescriber: Please check any of the following medications & preferred dose for each that may be given to the above named child while at school. These are the current stock medications available in the Nurses' Offices.

Acetaminophen (ie. Tylenol) - for minor discomforts associated with headache, fever or muscle pain

72-95 lbs./11 yrs. 480 mg., po, chewable tablets/liquid, q 4 - 6 hrs.

96 lbs. & over/12 yrs. 640 mg., po, chewable tablets/liquid, q 4-6 hrs.

12 yrs. & older - 650 mg. q4-6 hrs., po, tablets

Side Effects _____

Ibuprofen (ie. Motrin, Advil) - for minor discomforts associated with headache, fever or muscle pain – given with food

72-95 lbs./11 yrs. - 300 mg., po, chewable tablets/liquid, q 4-6 hrs.

12 yrs. & older – 400 mg. q4-6 hrs., po, tablets

12 yrs. & older – 200 mg. q4-6 hrs., po, tablet

Side Effects _____

Calcium carbonate USP 1,000 mg. (ie. Tums) - for upset stomachs, indigestion

1-2 chewable tablets po once per day at school

Side Effects _____

First aid items:

Triple antibiotic ointment for minor wounds

Hydrocortisone cream for itching from insect bites, rashes

Caladryl Clear for itching from insect bites, rashes

Opcon-A eye drops for itching, redness due to allergies

Side Effects _____

Side Effects _____

Date to Begin Administering Medications _____ 8/20/19 _____ Date to terminate Administering Medications _____ 6/5/20 _____

Licensed Prescriber's Name (print or type) _____ Phone _____

Licensed Prescriber's Emergency Phone _____

Licensed Prescriber's Signature _____

To be completed by parent:

Note: Any prescribed medication must be in a pill, capsule or in liquid form. It must be in a clearly marked container from a pharmacist. The label must show the student's full name, the dosage directions, the doctor's name and the prescription number. As a general rule, the School's personnel do not give injections. This form is valid for the current school year beginning with the first day of school in August.

The undersigned agree not to file or make any claim against anyone for negligence in connection with the administration or non-administration of any medicines and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines. **I am fully aware that requested medication may be, by necessity in the absence of the school nurse, self-administered under the supervision of medically unlicensed school personnel (OAC 4723-13-02).**

I have read the Guidelines for Administration of Medication at School and will abide by them. (over) As required by law, I will submit a revised form if there are any changes to the above information.

Signature of Parent/Parent Surrogate _____ Date _____

