Jefferson County Christian School

Over The Counter and Prescribed Medication Request Form

Student's Full Name:_____

Grade:_____ Age: ___ lb:_____ Teacher/Homeroom Class:_____

Over-the-counter Medication

I request that the school personnel administer the listed medications to my child as needed. **Unless noted on this form**, medication will be given as directed on package. **NO Medication** will be given without the signed permission from a parent/guardian. Please Note: If your child will be using any OTC medication with any frequency, it should be supplied from home (i.e. cough drops). Students are Not permitted to have any type of medication with them at any time, with the Exception of **Asthma** and/or **Epi-Pen** medication with the proper forms.

X_____

Parent/Guardian

Date signed _____ Cell#_____

Please list any vitamins, supplements, and/or dietary requirements to be received while at school.

_____

_____

OTC medication	YES	NO
Tylenol (Acetaminophen)		
Advil (Ibuprofen)		
Pepto Bismol/Mylicon		
Midol (Female student)		
Lip Balm		
Hand Lotion		
Saline Eye Drops / Eye Wash		
Tums / Children's Tummy Relief		
Antibiotic Ointment for cuts		
Cortisone Cream		
Benadryl /Allergy Medication		
Sore Throat Spray		
Cough Drops		
Modified Diet		
Other		

Prescription Medication - Any specific medication prescribed by your physician requires that physician's signature. This medication *MUST* be in the original container, currently dated, labeled with the name of the medication, the dosage, and the times to be given. The physician's name MUST also be on the label.

Name of Drug: _____ Today's Date:_____
Dosage: _____ Route: _____
Specific instructions for school medic/nurse/administrator:_____
_____
Possible side effects to watch for: _____
Expiration date for this request: _____

Physician's Signature X_____ Date: _____

<u>This section only needs filled out, if your child will be using an Asthma Inhaler</u>

Ohio Department of Health

Authorization for Student Possession and Use of an Asthma Inhaler

in accordance with ORC 3313.716/3313.14

A completed form Must be provided to the school medic, nurse, and /or principal before the student may possess and use an asthma inhaler in school to alleviate symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student's Name:
Student's address:

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to posssess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by on in which the student's school is a participant.

Signature Parent/Guardian X
Print Name Parent/Guardian X
Date:
Parent/Guardian emergency phone number:

Will the student keep the Asthma inhaler with them during school: Yes ____ No ____

Will the student keep the Asthma inhaler in the office: Yes ____ No ____

Will the student need the Asthma inhaler to accompany them to off campus athletic school events: Y / N

Name of Drug: _____ Today's Date:_____
Dosage: _____ Route: _____
Specific instructions for school medic/nurse/administrator:_____

_____
Possible side effects to watch for: _____
Expiration date for this request: _____

Physician's Signature X_____ Date: _____