Jefferson County Christian School

Over the Counter and Prescribed Medication Request Form

Student's Full Name:____

Grade:_____ Age: _______ 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 listed on package for age. **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 _________

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

____

____

OTC medication	YES	NO
Pepto Bismol/Mylicon		
Tylenol (Acetaminophen)		
Advil (Ibuprofen)		
Midol		
Lip Balm		
Hand Lotion		
Saline Eye Drops		
Cough Drops		
Antibiotic Ointment for cuts		
Cortisone Cream		
Benadryl /Allergy Medication		
Calamine lotion		
Tums		
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: ________