SEACREST
Country Day School

2010-2011 Authorization for Non-Prescription Medication

Please complete this form and return it to the Health Clinic.

Student's name: _____ Grade: _____

Weight: _____ DOB: _____

Please check all applicable medications.

- ☐ Advil or Ibuprofen
- ☐ Motrin or Ibuprofen
- ☐ Tylenol or Acetaminophen
- ☐ Midol
- ☐ Oral Benadryl
- ☐ cough drop/lozenge
- ☐ Robitussin CF
- ☐ Robitussin DM
- ☐ Dimetapp or Phenylephrine
- ☐ Sudafed PE or Phenylephrine
- ☐ Benadryl Spray
- ☐ hydrocortisone cream
- ☐ Neosporin Ointment
- ☐ Children's Pepto-Bismol
- ☐ Tums
- ☐ Visine

Dosage to be given: ***as per age/weight***

Time(s) medication is to be given: ***administer according to manufacturer's label recommended time schedule***

Effective dates for this authorization from: **August 2010** to: **June 2011**

_____ _____
(Print Health Care Provider's Name) Date

_____ _____
(Health Care Provider's Signature) Date

Parental Permission (To be completed by Parent/Guardian). Form is void if not completed.

I request the designated school personnel or its agents to assist my child in the administration of the above named prescription and non-prescription medications. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that (1) there is no liability on the part of the school, its personnel, or agents, and hereby release and waive any claims or actions against such persons or entity as the result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this mediation must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, or when the medication prescription expires, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel.

_____ _____
Parent/Guardian Signature Date