AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS

Please **cross off** any medications the student **may not** have, and enter any additional medications needed. These medications are stocked in the clinic and are available for general use **if parent and physician permission is given**. Physician approval, via signature and stamp, must be given for ALL over-the-counter medications.

| Name: | | Grade: | Allergies: | | |
|--|--------------|--------------------|--|---------------------------|---|
| MEDICATION | DOSAGE/ROUTE | FREQUENCY | INSTRUCTIONS | INDICATIONS | CHECK IF YOU REQUIRE PARENT CONTACT PRIOR TO ADMINISTRATION |
| Tylenol | Oral | q 6 hours | All medications will be administered by weight and/or age according to package instructions or as prescribed by the physician. | Headaches/ pain | |
| Advil | Oral | q 6 hours | | Muscular or skeletal pain | |
| TUMS Pepto- Bismol | Oral | PRN | | Upset stomach | |
| Benadryl | Oral | q 6 hours | | Allergic reactions | |
| Cough Drops | Oral | PRN | | Cough/ sore throat | |
| Benadryl Cream | Topical | PRN | | Itching/ bug bites | |
| Hydrocortisone Cream 1% | Topical | PRN | | Contact dermatitis | |
| Antibiotic Ointment | Topical | PRN | | Abrasions | |
| Directions: | n:lication: | | | | |
| Physician Stamp I hereby grant the school nurse or the above for my child during the school of | | | | | r the medications |
| Parent name: | | Parents signature: | | | Date: |

- Please call the school nurse at 954.771.4615 ext. 2524 with any questions.
- If parent chooses "Please attempt to contact first," an effort will be made to contact parent, however, permission is still given to administer medication in the event parent cannot be reached if physician has approved.
- All medications must be supplied in the original container. Ask your pharmacist to divide into two containers.
- It is your responsibility to notify the school when there is a change in medication or treatment regimen.
- ONLY medications authorized by a physician will be administered by school personnel.
- This form may be copied as needed.

HEALTH SERVICES FORM

WESTMINSTER ACADEMY

Information on this form will be shared with your child's school office. If you have a confidential matter, please call the clinic to discuss how we can address it to your satisfaction.

| Name: | Grad | e: Date of Birth: | |
|---|--------------------------|--|-----------------------------------|
| Height: | | Weight: | |
| Allergies/Illnesses/Conditions:(Please call the clinic if you would | like a copy of | the Westminster Academy Aller | gy Policy.) |
| Does your child have any health ne contact the clinic at 954.771.4615 | | | ours? If yes, please explain, and |
| Medications that affect the learn For grades PK-5: Inhalers are sto | ing process: (r | name, dose, and time) c. Epinephrine training is provid | ded for all teachers yearly. The |
| first EpiPen is kept in classroom in | teacher's care | the second is available in the s | school clinic. |
| For grades 6–12 only: | | | |
| If your child has asthma, does he/si | he have permis | sion to carry and self-administe | er his/her inhaler? |
| For grades 6–12 only: | | | |
| If your child requires an EpiPen, do | oes he/she have | e permission to carry and self-a | dminister the EpiPen? |
| (If your child carries an EpiPen at | school, please | provide the clinic with a secon | d pen as a backup dose.) |
| Does your child have any restriction If yes, explain: | | | |
| My child has authorization to parti release of information on this form | | | 1 0 |
| Parent/Guardian Name | Date | Parent/Guardian Signature | Date |
| For Clinic Use Only: Allergy Policy sent home Inhaler in clinic for student EpiPen in clinic for student | Expiration Expiration | n Date: | ice or Lower School Office |
| Date of request for EpiPen: Date of request for inhaler: Personal medications kept in clin | nic for student' | s use: | |