GreatHearts
classical education, revolutionary schools

Medical *Information* and Consent to Dispense Medications – SY 2018/2019

Student's Name (Please Print):_____**Birthdate:**_____

Known Allergies:_____

List All Medical Concerns:_____

School Provided *Non-Prescription Medications-*

Please check the medications below that the school nurse/office may dispense to your child:

- ☐ Advil (200 mg/tablet)
  - ☐ 1 Tablet
  - ☐ 2 Tablets
  - ☐ Liquid 100mg/5ml (per bodyweight)
- ☐ Tylenol (325 mg/tablet)
  - ☐ 1 Tablet
  - ☐ 2 Tablets
  - ☐ Liquid 160mg/5ml (per bodyweight)
- ☐ Benadryl (25 mg/tablet)
  - ☐ 1 Tablet
  - ☐ 2 Tablets
  - ☐ Liquid 12.5mg/5ml (per bodyweight)
- ☐ Antacid (TUMS)
- ☐ Cough Drop
- ☐ Saline Eye Drops
- ☐ Hydrocortisone Cream 1% (May apply no more than every 6 hours for itching).
- ☐ Antibiotic Ointment/Neosporin (May apply no more than every 8 hours for the prevention of infection in minor cuts, scrapes, or burns.)
- ☐ **DO NOT DISPENSE ANY MEDICATION TO MY CHILD.**

Parent Provided *Over-the-Counter Medications* – These are to be furnished by the parent, in the original container with the student's name and dosage instructions provided. Medications to be administered more than 10 days must have a physician's order. Medications not picked-up within 10 days will be disposed of in accordance to federal guidelines. Expired medication or medications without proper dosage instructions **will not** be administered to student.

Name of Medication	Route (by mouth, etc.)	Dosage	Time	Possible Side Effects

Parent Provided *Prescription Medications* – **All** medications must be furnished by the parent in the original container with affixed prescription label. No more than a 30 day supply of medication should be brought to the health office. All controlled substances should be brought into the health office by a Parent/guardian.

Name of Medication	Route (by mouth, etc.)	Dosage	Time	Expected Duration	Prescriber's Name	Indication for treatment	Possible Side Effects

Special Requirements (example: take with food):_____

Health Care Provider Name:_____Phone number:_____

I hereby authorize any hospital/doctor/EMS personnel to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

*Parent Contact 1: _____Phone number:_____

*Parent Contact 2: _____Phone number:_____

By signing below I give my consent for the school nurse or other designated school staff to dispense the medication(s) noted above to my child. I acknowledge that Great Hearts personnel are not responsible for any ill effects which may occur. **Note: The very first dose of this medication for current condition/illness may not be given at school.**

Signature of Parent/Guardian:_____Date:_____

Revised 2/25/2016

Signature of Parent/Guardian:_____Date:_____