



STUDENT MEDICAL HISTORY AND CONSENT TO DISPENSE MEDICATION

My signature below indicates my child _____ may to be given the following medications kept in the school clinic when deemed appropriate by the school nurse, teacher or office staff for the 2009-2010 school year.

Student's Grade _____ Age _____ Weight _____

Advil/Motrin/Ibuprofen*

Tylenol/Children's Tylenol/Acetaminophen*

Antibiotic Ointment

Moisturizing Eye Drops

Topical Treatment for bee stings/insect bites/skin irritations

TUMS/generic

I do not want my child to receive the medications that have been crossed off the above list.

*Dosages of the above listed medicines are based on the age and weight of the child unless otherwise requested by parents.

If your child suffers from allergies at any time (especially seasonal), PLEASE make sure you provide the office with allergy medication should it be needed. A consent form (available in both school offices) must be signed for all over-the-counter medications not listed above. Parents must provide medications such as *antihistamines, cough drops, cough syrup, decongestants, etc.*

ALLERGIES: _____

If your child REGULARLY takes any medications, please list them below:

MEDICATIONS: _____

Please list any pertinent *medical history* for your child (e.g. asthma, diabetes, etc.):

Child's Physician: _____

Telephone Number: _____

Date: _____

Printed Name of Parent or Guardian

Signature of Parent or Guardian

(_____) _____
Daytime Telephone Number

(_____) _____
Cell Telephone Number