

Request to Administer "Occasional-use" Medication

A release must be signed by a parent or legal guardian and on file in the health room each year for a student to receive medications at school, if such a need arises during a school day. Please indicate on the list below which medications the student may be given occasionally at school and the amount. Inhaler use information is below.

Please do not put daily medications, such as Ritalin, on the list below. A separate request form for prescription medication administration must be signed by the physician and the parent for the student to receive daily prescription medications at school.

PLEASE SIGN

I hereby certify that the student listed below has previously received at least one dose of the listed medication(s) and did not have an adverse reaction. I request that the listed medication(s) be administered at school as directed. I understand that any school employee who administers the medication to my child in accordance with the written instructions shall not be liable for damages as a result of an adverse drug reaction or because of a mislabeled or altered product.

Date _____ Parent/Guardian Signature _____

Student name _____ Age _____

Upon request, the above named student may receive during a school day. **Please indicate the amount you normally give your child.**

- Acetaminophen-Children's Liquid, 160 mg/teaspoon Amount _____
- Acetaminophen-Junior Chewable, 160 mg/tablet Amount _____
- Acetaminophen-Adult Regular, 325 mg/tablet Amount _____
- Acetaminophen-Extra-Strength, 500 mg/tablet Amount _____
- Ibuprofen-Children's Liquid, 100 mg/teaspoon Amount _____
- Ibuprofen-Junior Chewable, 100 mg/tablet Amount _____
- Ibuprofen-Adult Strength, 200 mg/tablet Amount _____
- Occasional cough/sore throat drops or antacid tablets Amount _____
- Benadryl-liquid; for allergic reactions Amount _____ Drowsiness YES NO
- Other occasional-use medication (**Please list name, instructions, and reason for medication. The medication must be in the original container, labeled with the student's name.**)
Amount _____
Amount _____
- No medication to be dispensed to my child unless in an emergency situation that has been evaluated by school personal or emergency services.**

For Students Who Use Inhalers

This student is responsible and properly trained in the use of inhalers and may self-administer the above medication(s) as needed during the school year. The student knows to never share medication with another student and to keep the inhaler with them or in their book bag at all times.

A separate request form for the self-administration of an inhaler must be signed by the parent and the physician.

I prefer that this student be supervised by school personnel for administration of inhaled medications.

A separate request form must be signed by the parent and the physician for an inhaler to be administered to the student at school.

Parent/Guardian Signature _____

Topeka Collegiate School Health Form 2011-2012

Student Name _____ Birth Date _____ Grade _____

Home Address _____ Home Phone _____

Mother's Name _____ Cell Phone _____ Work Phone _____

Father's Name _____ Cell Phone _____ Work Phone _____

Stepparent/Guardian _____ Cell Phone _____ Work Phone _____

Health History: Allergies to medication yes no. If yes, please list medications.

List other allergies and reactions:

Please check health concerns your child currently has:

- | | | | | |
|---|-----------------------------------|--|--|---|
| <input type="checkbox"/> vision problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> headaches | <input type="checkbox"/> heart problems | <input type="checkbox"/> nosebleeds |
| <input type="checkbox"/> hearing problems | <input type="checkbox"/> seizures | <input type="checkbox"/> stomach upset | <input type="checkbox"/> frequent ear infections | <input type="checkbox"/> skin rashes or hives |
| <input type="checkbox"/> speech problems | <input type="checkbox"/> asthma | <input type="checkbox"/> fainting spells | <input type="checkbox"/> attention deficit | <input type="checkbox"/> other _____ |

Please explain if any of the health concerns may require special attention at school _____

List medications the student regularly takes _____

In the event that a parent/guardian cannot be reached, please list someone in the area who may be contacted in the event of illness or injury:

Name _____ Home Phone _____ Work Phone _____

Relationship _____ Cell Phone _____

Student's Physician _____ Office Number _____

In case of emergency, at which hospital do you want your child treated? _____

PLEASE SIGN

I hereby authorize the physician in charge of (student name) _____ to administer any treatment or to administer such anesthetics, perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I accept the treatment deemed necessary by the physician treating the emergency. If time allows I prefer that the above named physician treat my child. I hereby give my permission for my child's medical information to be shared with other Topeka Collegiate School personnel.

I agree to hold Topeka Collegiate School harmless for any injury incurred by my child as a result of typical play and participation in school activities and agree to pay all costs and fees incurred for medical treatment.

Date _____ Parent/Guardian Signature _____

Last tetanus immunization _____ Witness Signature _____