

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 _____

No medication is to be dispensed to the above named student unless in an emergency situation deemed necessary by school personal or emergency services.

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 _____

For Students Who Use Inhalers

This student is responsible and properly trained in the use of inhalers and may self-administer 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 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 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 2010-2011

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:

Vision problems ___ diabetes ___ headaches ___ heart problems ___ nosebleeds ___
hearing problems ___ seizures ___ stomach upset ___ frequent ear infections ___ skin rashes or hives ___
speech problems ___ asthma ___ fainting spells ___ attention deficit ___ 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 _____ Relationship _____
Home Phone _____ Work Phone _____ 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 _____