Over the Counter Medication Release

The staff of Campion Academy will not be able to administer any medications to your student without this form being **signed by someone with prescriptive authority**. Please have your health care provider mark each medication that the staff can administer as directed on the medication.

Students Name _____ Date of Birth _____

__ Acetaminophen (headaches, general aches and pains)
__Acetaminophen, dexromethorphan HBr, Doxylamine Succinate (Nyquil cold)
__ Activated Charcoal (Upset stomach, diarrhea, gas)
__ Alcohol Swab (Antiseptic skin prep)
__ Aloe Vera (sunburn and minor burn relief)
__ Antiseptic Wash (for minor cuts, scrapes and burns)
__ BioFreeze (temporary relief of minor aches and pains of sore muscles and joints)
__ Calcium Carbonate (antacid tablets)
__ Cetrizine HCI (24 hour allergy relief, seasonal allergies)
__ Chap Stick
__ Cough drops
__ Diphenhydramine HCL (allergies, hives, night time sleep aid)
__ Glucose (Low blood sugar)
__ Guaifenesin
__ Hydrocortisone cream
__ Ibuprofen (headaches, general aches and pains)
__ Imodium and generic (diarrhea)
__ Lip Clear plus Lysine (cold sores)
__ Loratadine (24 hour allergy relief, seasonal allergies)
__ Melatonin (Sleep aid)
__ Midol and generic for Female students (contains Acetaminophen, caffeine, pyrilamine maleate for menstrual relief)
__ Phenylephrine HCI (sinus decongestant)
__ Purified water (eye wash)
__ Povidone-Iodine swab (Antiseptic/Germicide used to clean minor wounds)
__ Saline Spray (wound wash)
__ Saline Nasal spray (Relief of dry nasal membranes)
__ Sodium Carboxy-methylcellulose (eye lubricant)
__ Sun Screen
__ Triple antibiotic Ointment
__ Throat Spray (Sore Throat)
__ Vitamin C

__ All of the following medications can be administered
__I decline the opportunity for any medications to be given to the above mentioned child while at Campion Academy or under the care of Campion Academy.

Health Care Providers Signature: _____ Date _____
Health Care Providers Name and Phone Number:_____
Health Care Providers Address: _____
Parent/Guardian Signature: _____ Date_____

CONSENT FORM-PRESCRIPTION MEDICATION ADMINISTRATION

(please complete one for each medication the student takes)

Name of child_____ Date of birth_____
Name of medicine_____
Purpose of medicine_____
Instructions (dosage, frequency, how many days) _____
Comments_____
Signature of physician_____ Date_____
Physician's Printed Name_____
Address_____ Phone_____
_____**I give permission** for the above named child to take the above medication at school as prescribed. I understand that the medication must be provided in a container appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and the frequency
_____**I affirm that my child does not have any prescription medications**
Signature of Parent or Legal Guardian: _____ Date: _____
Parent/Guardian's Printed Name: _____

CONSENT FORM-PRESCRIPTION MEDICATION ADMINISTRATION

Name of child_____ Date of birth_____
Name of medicine_____
Purpose of medicine_____
Instructions (dosage, frequency, how many days) _____
Comments_____
Signature of physician_____ Date_____
Physician's Printed Name_____
Address_____ Phone_____
_____**I give permission** for the above named child to take the above medication at school as prescribed. I understand that the medication must be provided in a container appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and the frequency
_____ **I affirm that my child does not have any prescription medications**
Signature of Parent or Legal Guardian: _____ Date: _____
Parent/Guardian's Printed Name: _____

CONSENT FORM-PRESCRIPTION MEDICATION ADMINISTRATION

Name of child_____ Date of birth_____
Name of medicine_____
Purpose of medicine_____
Instructions (dosage, frequency, how many days) _____
Comments_____
Signature of physician_____ Date_____
Physician's Printed Name_____
Address_____ Phone_____
_____**I give permission** for the above named child to take the above medication at school as prescribed. I understand that the medication must be provided in a container appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and the frequency
_____ **I affirm that my child does not have any prescription medications**
Signature of Parent or Legal Guardian: _____ Date: _____
Parent/Guardian's Printed Name: _____

CONSENT FORM-PRESCRIPTION MEDICATION ADMINISTRATION

Name of child_____ Date of birth_____
Name of medicine_____
Purpose of medicine_____
Instructions (dosage, frequency, how many days) _____
Comments_____
Signature of physician_____ Date_____
Physician's Printed Name_____
Address_____ Phone_____
_____**I give permission** for the above named child to take the above medication at school as prescribed. I understand that the medication must be provided in a container appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and the frequency
_____ **I affirm that my child does not have any prescription medications**
Signature of Parent or Legal Guardian: _____ Date: _____
Parent/Guardian's Printed Name: _____