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 _____

**__ 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.**

__ Acetaminophen
__ Activated Charcoal
__ Alcohol Swab
__ Aloe Vera
__ Antiseptic Wash
__ Benadryl and generic (Diphenhydramine HCL)
__ BioFreeze and generic
__ Bug Spray
__ Calcium Carbonate
__ Cetirizine HCl
__ Cough drops
__ Glucose (Low blood sugar)
__ Hydrocortisone cream
__ Ibuprofen
__ Imodium and generic
__ Lip Clear plus Lysine
__ Instant Cold Spray (tendon/ligament injuries)
__ Loratadine
__ Lubricating eye drops
__ Melatonin
__ Midol and generic for Female students (Acetaminophen, caffeine, pyrilamine maleate)
__ Mucinex and generic (Guaifenesin)
__ Purified water (eye wash)
__ Saline Spray (wound wash)
__ Saline Nasal spray (Relief of dry nasal membranes)
__ Sudafed and generic (Phenylephrine HCI)
__ Sunscreen
__ Antibiotic Ointment
__ Throat Spray
__ Tylenol Cold (daytime and nighttime) and generics (Acetaminophen, Dextromethorphan HBr, Phenylephrine HCl, Doxylamine succinate)
__ Vitamin C
__ Zinc

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

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## 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: _____