CINCINNATI HILLS CHRISTIAN ACADEMY (2017-2018)

School Medication Permission Form **– Preschool Students Only**

(For both Over-the-Counter and Prescription Medications)

In accordance with Ohio Revised Code 3313.713 and our School Medication Policy (found in the Family Information Guide), a parent/guardian consent **and** doctor/dentist consent is required for **all** medications to be given to a student by school personnel. **This includes over-the-counter medication.** All requested information must be completed in full, including **physician's signature** and returned to the health room.

This area to be completed in full by the parent / guardian

Name of Student_____ Date of Birth_____ Grade_____

Student's Address_____ CHCA Building_____ Home Room_____

Student Allergies: Food(s)_____ Drug(s) _____Student Wt. _____

I authorize a Cincinnati Hills Christian Academy nurse or school personnel to administer medication as instructed to my child. I agree to deliver the medication in a timely manner to the school in the original container with pharmacy label if applicable. I will notify the school if I change physicians or if the medication is changed or eliminated. I understand it is the student's responsibility to report on time for this medication. I fully release Cincinnati Hills Christian Academy, its employees and Board of Trustees from all liability related to the administration of this medicine.

Parent/Guardian Signature_____ Printed Name _____Date_____

Phone during school hours: #1_____ #2_____

Circle one: Home / Work / Cell Circle one: Home / Work / Cell

Parent/Guardian Signature_____ Printed Name _____ Date_____

Phone during school hours: #1_____ #2_____

Circle one: Home / Work / Cell Circle one: Home / Work / Cell

This box to be completed in full by the physician:

NOTE: If dose is not indicated below for Over the Counter Medications, directions for age/weight provided on package, will be followed.

Date of Authorization_____ Start Date _____ Stop Date _____

- ❑ Acetaminophen Junior (ie. Tylenol Jr.- Q4 to 6 hours PRN-Oral) _____160mg. _____320mg. _____480mg.
- ❑ Ibuprofen Junior (ie. Motrin Jr. or Advil Jr. – Q 6 to 8 hours PRN – Oral) : _____ 50mg ____100mg. ____ 150mg.

- ❑ Other Medication_____ Dosage / Route_____
  Time(s) to be given:_____ Frequency_____

First aid items:

- ❑ Triple antibiotic ointment for minor wounds
- ❑ Hydrocortisone cream (1%) for itching
- ❑ Caladryl Clear for itching from insect bites, rashes

Allergies: for orders related to specific symptoms submit an Allergy Action plan found on the CHCA website.

- ❑ Diphenhydramine HCL (ie Benadryl) - _____ mg oral route, Q_____hours for minor allergic reactions
- ❑ EpiPen Jr. _____ mg , IM, into outer thigh and call 911 for emergency treatment of severe, life threatening allergic reaction
- ❑ Asthma Inhaler_____- _____puffs Q_____ PRN for wheezing, shortness of breath, cough

Adverse reactions to be reported for any listed medication _____

Special instructions: _____

Procedure to follow in the event medication does not relieve symptoms: _____

Prescribing physician (print) _____ **Signature**_____

Physician emergency telephone_____ Alternate phone #_____ Fax #_____

E.B.L. Elementary School (513) 247-9944 x 109 Fax (513) 247-0125
Otto Armleder Education Center (513) 721-2422 x 405 Fax (513)721-3300

THIS PERMISSION FORM IS NO LONGER VALID AFTER THE END OF THE CURRENT SCHOOL YEAR (REV. 1-10-17 DDC)

Created on 1/12/2017