Park County School District RE-2
Health Services Permission

Name of Student: ____Grade________

Student's age _____Student's weight _____ Allergies __________________________________

Parent/Guardian Name: ____

Listed below are non-prescription medications/remedies available at the Student Health Office. Please cross out any medications/remedies you **do not want your child to take or use.**

Acetaminophen (Tylenol)** *Ibuprofen* *Antacid Tablets (Tums)* *Antihistamine (Benadryl)

Aloe Vera Gel Sunscreen Buffered Eye Wash Vaseline

"Hurt Free" Antiseptic Wash for Wounds Antibiotic Ointment (Neosporin)

Anti- Itch Lotion (Caladryl) Contact Lens Solution Lemon-lime Soda

Olive Oil Drops (ear pain) Cough Drops Lotion Gatorade Ginger ale

**** Underlined Oral Medications will not be given without notification of Parent or Guardian ****

If you would like us to give medications **not listed,** a physician's written permission is required. We need a **Medication Administration Authorization Form** for each medication to be administered, including over the counter medications not listed above.

I understand it is my responsibility to:

1. Furnish medication that is not expired, in it's original pharmacy bottle with student's name.
2. Supply a doctor's signature on the Medication Administration Authorization Form, including over the counter medications not listed above, including remedies, vitamins, ointments, & homeopathic remedies.
3. Supply a new authorization form for medication dosage, time, or frequency changes.
4. Supply refills before any doses are missed.

I understand that without furnishing the **legal requirements listed above**, medications **cannot** be given.

I will provide the Student Health Office with written documentation of any changes in the statements above or any changes in my child's circumstances that might affect their health or change the care they should be given.

I hereby give permission for my child, named above, to take over the counter medications/remedies listed above at school. (unless crossed out)

I understand that this agreement will be in effect until I provide a written statement withdrawing my consent.

Signature: ____ **Date:** _______________

Dear Parent or Guardian,

Our Health Services Office is now able to give over the counter medications & remedies to our students. Please read and fill out the back of this form in order to allow your child to receive, or to exclude your child from these medications/remedies.

You must cross out any medication/remedy that you do not want your child to receive

No oral med. will be given without contacting parent or guardian
Medications cannot be given without parent's signature on form

Return the form to your child's classroom teacher. If you have questions please call 719-836-4426.

Thank You,

Jean Ashby LPN
Park County Re-2 School Nurse