

The Calvary Academy
11970 Kenn Road, Cincinnati, OH 45240
(513) 674-9600 Fax (513) 674-9602

NON-PRESCRIPTION MEDICATION – Must be completed and returned
With your permission, non-prescription medication will be administered by the school's nurse or other designated person as needed. Please be aware that we will have only non-prescription medications listed below available. Any other non-prescription medication will need to be provided by the student's parent/guardian. This medication should come in the original container with expiration date visible. Label the container with the student's name and bring to the school office. In addition it will be your responsibility to retrieve any remaining medication at the end of the school year. Medications remaining in the office after summer dismissal will be disposed of.

Student's Name _____

Grade _____ Age _____

Pertinent medical information (allergies, medical conditions) _____

Please indicate your preference below regarding the administration of non-prescription/over the counter medication (Please check if permitted):

Non-Prescription Medication:

- _____ Children's Motrin (Ibuprofen)
- _____ Junior Strength Ibuprofen (Ages 6-11)
- _____ Children's Tylenol (Acetaminophen)
- _____ Junior Tylenol Meltaways (Ages 6-11)
- _____ Tums – upset stomach
- _____ Benadryl/Allergy

Adult Tylenol is only given to students over 12 years or 100 pounds. All other students get children's products.

- Ibuprofen
- Tylenol

Any other non-prescription medication must be provided by parents and kept in the school office.

Female products must be sent with students.

Parent/Guardian Signature _____ Date _____

Please do not give my child any medication without my written or phone permission.

Parent/Guardian Signature _____ Date _____

PRESCRIPTION MEDICATION

(Complete only if your child will need to take prescription medicine during school hours)
School policy requires consent of the parent/legal guardian and a written order from the licensed prescriber before medication can be given to a student by school personnel. All requested information must be completed in full and returned to the school office.

No student is allowed to carry or place in his/her locker, lunch box, backpack, purse, etc., unapproved medication (this includes Tylenol). With few exceptions, medications will be stored and dosages taken in the school office.

Student's Name _____

DOB _____ Grade _____

Address _____ Phone _____

TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER

The above named student is under my care for _____

Diagnosis

and should receive _____

Name of Medication

Dosage and Route

at the following times _____

Specific instructions for administration: _____

Possible side effects: _____

Effective date _____ Expiration date of this request _____

Licensed Prescriber Signature

Date

Phone number

MEDICATION MUST COME TO SCHOOL IN THE ORIGINAL CONTAINER WITH THE AFFIXED LABEL FROM THE PHARMACY. THE LABEL MUST SHOW THE STUDENT'S NAME, THE NAME OF THE MEDICATION, THE DOSAGE DIRECTIONS, AND THE PRESCRIBER'S NAME.

TO BE COMPLETED BY PARENT/GUARDIAN

I give my permission for the school's R.N. or designated person to administer the medication as prescribed above to my child and further agree to:

- 1) Submit to the school nurse a revised statement signed by the licensed prescriber of the above medication when any change in the original order occurs or is discontinued.
- 2) Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication.
- 3) Provide safe transportation of the medication to and from school.

Parent/Guardian Signature

Date

THIS PERMISSION FORMS IS NO LONGER VALID AFTER THE END OF THE SCHOOL YEAR