

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS AT SCHOOL WESTMINSTER ACADEMY®

Please **cross off** any medications the student **may not** have, and enter any additional medications needed. These medications are stocked in the clinic and are available for general use **if parent and physician permission is given. Physician approval must be given for ALL over-the-counter medications.**

NAME: _____ GRADE: _____ ALLERGIES: _____

| MEDICATION | DOSAGE AND ROUTE | FREQUENCY | SPECIFIC INSTRUCTIONS | SPECIAL INSTRUCTIONS | PLEASE ATTEMPT TO CONTACT PARENT FIRST |
|---------------------------|------------------|-----------|--|--------------------------------|--|
| Tylenol | p.o. | q 4 hours | All medications will be administered by weight and/or age according to package instructions or as prescribed by the physician. | For headaches or stomach aches | Yes No |
| Advil | p.o | q 6 hours | | For muscular or skeletal pain | Yes No |
| Tums/Mylanta/PepetoBismol | p.o | p.r.n. | | For upset stomach | Yes No |
| Benadryl | p.o. | q 6 hours | | Allergic reactions | Yes No |
| Antibiotic Ointment | Topical | p.r.n. | | Abrasions | Yes No |
| Benadryl Cream | Topical | p.r.n. | | Itching or bug bites | Yes No |
| 1% Hydrocortisone Cream | Topical | p.r.n. | | For contact dermatitis | Yes No |
| Cough drops (OTC) | p.o. | p.r.n | | For cough or sore throat | Yes No |

Other Medication: _____ Dosage: _____

Time and directions for dispensing: _____

Purpose for medication: _____ Possible side effects: _____

Physician Stamp

Physician Signature

Date Completed

I hereby grant the school nurse or the headmaster's designee the permission to administer the medications above for my child during the school day.

Parent/Guardian name (Printed)

Signature of Legal Parent/Guardian

Date Signed

- Please call the school nurse at 954.771.4615 ext.2524 with any questions.
- If parent chooses "Please attempt to contact first", an effort will be made to contact parent, however, permission is still given to administer medication in the event parent cannot be reached if physician has approved.
- All medications must be supplied in the original container. Ask your pharmacist to divide into two containers.
- It is your responsibility to notify the school when there is a change in medication or treatment regimen.
- ONLY medications authorized by a physician will be administered by school personnel.
- This form may be copied as needed.

Form may be faxed to 954.334.6166

HEALTH SERVICES FORM
WESTMINSTER ACADEMY®

Information on this form will be shared with your child's school office. If you have a confidential matter, please call the clinic to discuss how we can address it to your satisfaction.

Name: _____ **Grade:** _____ **Date of Birth:** _____

Height: _____ **Weight:** _____

Allergies/Illnesses/Conditions: _____
(Please call the clinic if you would like a copy of the Westminster Academy® Allergy Policy.)

Does your child have any health needs that require nursing care during school hours? If yes, please explain, and contact the clinic at 954.771.4615 x2524 to discuss a care plan:

Medications that affect the learning process: (name, dose, and time) _____

For grades Pre-K-5th: Inhalers are stored in the clinic. Epinephrine training is provided for all teachers yearly. The first Epipen is kept in classroom in teacher's care; the second is available in the school clinic.

For grades 6-12 only:

If your child has asthma, does he/she have permission to carry and self-administer his/her inhaler?

For grades 6-12 only:

If your child requires an Epipen, does he/she have permission to carry and self-administer the Epipen?

(If your child carries an Epipen at school, please provide the clinic with a second pen as a backup dose.)

Does your child have any restrictions on his/her activities? Yes No

If Yes, explain: _____

My child has authorization to participate in the regular school physical education program. I authorize the release of information on this form to WA school personnel to be used in the educational interest of my child.

Parent/Guardian Name

Parent/Guardian Signature

For Clinic Use only:

Copy to Athletic Office or Lower School Office

Allergy Policy sent home

Inhaler in clinic for student

Expiration date: _____

Epipen in clinic for student

Expiration date: _____

Date of request for Epipen: _____

Date of request for inhaler: _____

Personal medications kept in clinic for student's use: _____
