

# John Paul the Great Academy

## 2017-2018 Medication Administration Form

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please identify any current medical conditions and/or allergies:

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Please initial the following:

I authorize the front office personnel to dispense the following medications to my child as needed:

\_\_\_\_\_ Acetaminophen (Tylenol)

\_\_\_\_\_ Ibuprofen (Advil)

\_\_\_\_\_ Benedryl

\_\_\_\_\_ Imodium/Pepto/Tums (for upset stomach)

\_\_\_\_\_ Cortizone 10 or Calamine Lotion (for bites/stings)

\_\_\_\_\_ If my child needs any other medication, including **prescription and/or over the counter**, it will be **turned into the front office in it's original container and appropriately labeled with my student's name**. **A parent or guardian must fill out the medication section on the back of this form for any medication brought to the office**. The medication name and dosage & frequency must be listed on the back of this form. Students are not allowed to keep any medication on them at any time unless noted by physician with the exception of **cough drops**.

In the event of an emergency, if I cannot be reached at the phone numbers given in my child's registration information, please contact the following:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

I have read and understand the above initialed guidelines regarding medication for my child. The information provided in this form is correct to the best of my knowledge. I authorize the school staff to administer the nonprescription and prescription medication(s) noted herein.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

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