



Village Christian Academy
Consent for Administration of Over-the-Counter Medication

Name of Child: M F Birthdate Grade
Parent/Guardian Home phone
Work Phone Cell#
Emergency Contact (other than above) Phone #
Doctor: Dentist: Preferred Hospital:
Permission to transport: Y N Health Insurance:
Accident Insurance:

In an effort to provide better care for your student during school hours we will make available basic over-the-counter (OTC) medications. These are non-prescription medications which will be available at no charge. NOTE: WE WILL NOT administer any medications unless we have your signed, dated permission. This form is updated yearly. More frequently if health information changes.

I would like the following medication(s) made available to my child. Please check medications that you approve to be given, or:

MAY RECEIVE ALL MAY RECEIVE NONE CALL PARENT PRIOR TO ANY TREATMENT

- For headache, fever, pain, or menstrual cramps: Acetaminophen (Tylenol) or Ibuprofen (Advil, Motrin)
For sinus headaches, allergies, Hay fever: Acetaminophen (Tylenol) Sinus
For stuffy/runny/nose/cough: Acetaminophen (Tylenol)(Cold medicine, Decongestant, or Antihistamine)
For sore throat/cough: Lozenges/cough drops, throat spray (Chloraseptic)
For tooth, gum, lip, brace, or cold sore pain: Oragel, Ambesol, or lip balm
For stomach upset: Antacid, liquid or chewable
For cuts and abrasions: Triple antibiotic ointment/cream, peroxide, Bactine spray
For insect bites: Topical anesthetic/Benadryl ointment or spray
For rashes (poison ivy/oak, etc.): Benadryl ointment, Benadryl liquid/capsules/chewable tabs, Calamine lotion, Hydrocortisone cream
For sun safety: Sunscreen lotion/spray

I understand that generic equivalent medications may be used. I also understand that the above medications I have checked will be administered by the Health Specialist, School Nurse or trained designate in accordance with established medical protocols.

Parent/Guardian Date

SCHOOL HEALTH QUESTIONNAIRE

MEDICATION, FOOD, OR ENVIRONMENTAL ALLERGIES/SENSITIVITIES:

Will your child require an Epi-pen or ANA kit at school? Yes No
Names of any medications given daily:
Need to be given at school? Yes No
Childhood diseases/major illnesses/accidents/surgeries:

Health History (check and explain):
Asthma Y N Hearing problems Y N
Diabetes Y N Vision Problems Y N
Heart problems Y N Orthopedic problems Y N
Seizures Y N Other health problems

Explain any additional comments or concerns about your child's health, development, behavior, home, or family life that is pertinent:

Parent/Guardian Signature: Date:
Health Specialist or School Nurse Signature: Date: