Student's Name: ______________________ Grade:___________ Birth Date: ____________
(one student per form)

Alburnett Community Schools

Over-the-Counter (Non-Prescription) Medication Administration Form

2012-2013

A registered nurse or qualified designated school personnel who have completed a medication course will have the following over-the-counter medication available to give to students according to written protocol and with written parental authorization. Please check the medications the above child may receive for minor health problems during the 2012-2013 school year.

****NO over-the-counter medications will be administered without written consent from parent or guardian.****

List all medical conditions or special needs: ____

____

List any illnesses, operations, or accidents your child has had in the past year: __________________

____

Any Known Allergies: ______________________________________ Weight: __________

Routine Medications: ____

Doctor's Name and Phone #: ____

Dentist's Name and Phone #: ____

Check one:

May give all medications listed according to the listed dosages for weight and symptoms

Give ONLY medications checked according to the listed dosages for weight and symptoms

Do NOT give any medications

Acetaminophen (Tylenol) 325 mg 1 or 2 tablets every 4 hours headache, cold, sore throat, menstrual cramps, earache	Acetaminophen (Tylenol) 160mg 1 or 2 chewable tablets every 4 hours headache, cold, sore throat, menstrual cramps, earache
Ibuprofen (Advil, Motrin) 200mg 1-2 tablets every 4 hours menstrual cramps, muscle strain, backache, headache	Ibuprofen (Advil, Motrin) 100 mg 1 to 2 tsp every 4 hours menstrual cramps, muscle stain, backache, headache
Cough drop (cough suppressant) 1 every 1 to 2 hours cough or sore throat	Antacid (Tums, Rolaids) 1-2 tablets every 4 hours upset stomach or heartburn

Please administer the above medications as needed according to listed dosages and symptoms for the student listed above. I agree the information on this form can be shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA).

Date:_________________ Parent/Guardian Signature: ______________________________________

Mom's Name/Day Phone:________________________________ Cell Phone:________________________

Dad's Name/Day Phone: ________________________________ Cell Phone:________________________

Emergency Contact:___________________________________ Relationship:______________________

Day Phone:____ Cell Phone:________________________

Emergency Contact:___________________________________ Relationship:______________________

Day Phone:____ Cell Phone:________________________