Clayton Public Schools

Over-the-Counter Medication Consent & Medical Update

Parents/Guardians must complete page 1 & 2 of this form, and sign at the bottom!

Student Name _____Grade_____Date of Birth_____

Over-the-Counter Medication Consent Parental Permission *only*:

To keep your child as comfortable as possible during the school day, and to treat your child for muscle aches, headaches, menstrual cramps, and minor discomforts, etc., without disrupting their education, please complete the section below. *No calls will be made home to administer over-the-counter medication!*

- ☐ My child has **NO KNOWN DRUG** allergies
- ☐ My child has **NO KNOWN FOOD** allergies
- ☐ **YES**, I give permission for my child to have the Over-the-Counter Medications checked below:
- ☐ **Tylenol**/Acetaminophen per package dosing based on age/weight
- ☐ **Advil**/Motrin/Ibuprofen per package dosing based on age/weight
- ☐ **Tums** For upset stomach, indigestion/heartburn
- ☐ **Cough Drop** For cough, sore/scratchy throat
- ☐ **Benadryl/**Diphenhydramine for emergency purposes only; *not for daily allergy maintenance*, per package dosing based on age/weight.
- ☐ **NO**, I Do NOT give permission for my child to have the medications listed above, during school hours

My child is Allergic to the following medications:_____

_____

Specific instructions from parent, if any:_____

Medical Update:

Please **CHECK** the medical conditions below that apply to your child, and **CIRCLE** if your child needs medication during school. If your child needs any medication other than over-the-counter meds, please have the *Dr. complete the Action Plan/Medication Consent FORM that applies to your child's medical need. Those FORMS can be printed from the school's website.*

- ☐ **Food Allergies**
- ☐ **Environmental Allergies**

My child's allergies are:_____

_____

My child's food and/or environmental allergies may require an EpiPen or EpiPen Jr. **Circle: Yes or No**

- ☐ **Asthma/wheezing**

My child's asthma may require an inhaler **Circle: Yes or No**

- ☐ **Seizures**

Last known seizure was on **DATE**:_____

Emergency Seizure Medications, please list: _____

My child seizures require emergency medication to be given at school **Circle: Yes or No**

- ☐ **ADHD, ADD, ODD, OCD, Autism, etc.**

Medication name:_____

My child requires this medication to be given at school **Circle: Yes or No**

- ☐ **OTHER** Medical Conditions not listed above_____

_____

My child requires medication to be given at school **Circle: Yes or No**

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Student Name _____Grade_____Date of Birth_____

Insurance Information:

My child has Health Insurance Coverage **Circle: Yes or No**
If yes, please provide Health Insurance Company: _____

Dr. Name_____ **Dr. Phone**_____

If not, NJ FAMILY CARE provides low-cost or free health insurance for uninsured children in certain low-income families. For more information call (800) 701-0710 or visit www.njfamilycare.org to apply

_____

The information on this form is correct, and I give my permission to the school nurse to share pertinent health information regarding my child with essential school personnel, emergency contacts, and my child's healthcare provider, if needed. I acknowledge that the school nurse and staff shall incur no liability because of any condition arising from decisions made on behalf of my child and in the best interest of my child's health and welfare. I indemnify and hold harmless the school and its employees or agents against claims arising from the decisions made on behalf of my child and in the best interest of my child's health and welfare.

Healthy Regards,
Mrs. Sherry L. Richards BSN, RN, CSN-NJ, HS & MS
srichards@claytonps.org

X_____X_____ X_____
Signature of Parent/Guardian **Printed** Parent/Guardian Name **Date**

*This form must be **completed** and **signed** by **PARENT/GUARDIAN**, in **September of every school year!***
NO Dr. signature is required for this form!