Clayton Public Schools

Over-the-Counter Medication Consent & Medical Update

*Parent/Guardian must complete this form **every September**!*

Students Name: _____Grade:_____Date of Birth:_____

Over-the-Counter Medication *Parent/Guardian Permission only*

Complete the section below to keep your child as comfortable as possible during school and treat them for muscle aches, headaches, menstrual cramps, minor discomforts, etc., without disrupting their education. *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 permit 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 permit my child to have the above medications during school hours.

My child is Allergic to the following Medications:_____

_____

Specific instructions from Parent/Guardian, if any:_____

Medical Update

CHECK the medical conditions below that apply to your child, and **CIRCLE** if your child needs medication during school. **IF** your child needs medications for the conditions you checked, have your child's Healthcare Provider fill out the corresponding forms and return them to the School Nurse. All other forms are on the school's website.

☐ **ADHD, ADD, ODD, OCD, Autism, etc.:** If circle YES, Prescription Medication Consent is required!
My child needs medication during school for this diagnosis…… **Circle:** Yes or No
Medication taken at home:_____Medication needed during school:_____

☐ **Allergies; Food & Seasonal:** If circle YES, Allergy Action is required!
My child needs medication during school for allergies…… **Circle:** Yes or No
My child is allergic to the following:_____

☐ **Asthma/Wheezing**: If circle YES, Asthma Action Plan is required!
My child needs medication during school for asthma…….. **Circle:** Yes or No

☐ **Diabetes:** If circle YES, Diabetes Action Plan is required!..... **Circle**: Yes or No

☐ **Seizures:** If circle YES, Seizure Action Plan is required!
My child needs medication during school for seizures…… **Circle:** Yes or No
Medication taken at home:_____Medication needed during school:_____
Date of last known seizure:_____

☐ **OTHER** Medical Conditions not listed above_____
My child needs medication during school for this condition…….. **Circle:** Yes or No
Medication taken at home:_____Medication needed during school:_____

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Insurance Information

My child has Health Insurance Coverage **Circle:** Yes or No

If YES, please provide Name of Health Insurance Company below:

_____

Healthcare Provider's **Name**_____Healthcare Provider's **Phone** _____

If you do not have insurance, 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. If needed, I permit the school nurse to share pertinent health information regarding my child with essential school personnel, emergency contacts, and my child's Healthcare Provider. 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 the school and its employees or agents harmless 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. S. Richards BSN, RN, CSN-NJ
Middle School & High School Nurse
Srichards@claytonps.org

_____ _____ _____

Parent/Guardian **Signature** Parent/Guardian **Printed** Name **Date**

~Last year's Over-the-Counter Medication Consent & Medical Update has expired!

~Healthcare Provider's signature is NOT required for this form!

~All other forms are on the school's website under High School Nurse!

Updated 7/21/23 by CPSD HS & MS, SLR