Delmarva Christian High School
Non-Prescription Medication Administration Form

Student Name: _____ DOB: _____ Allergies: _____

Current Medications: _____

**Please check each medication your child may receive on an as-needed basis from the school nurse.*

___ Anbesol or Orajel ___Benadryl ___ Benadryl Topical Lotion or Spray ___ Calamine Lotion ___ Cough Syrup ___ Cough Drops ___ Hydrocortisone Cream ___ Insect Repellent *(Parent must provide)*	___ Motrin or Advil ___ Neosporin ___ Sterile Eye Wash ___ Sunscreen *(Parent must provide)* ___ Tums or Maalox ___ Tylenol ___ Vaseline *(Used as skin/lip protectant)* ___ _____ ___ _____

1. The parent or guardian **MUST** make school nurse aware of any allergies [especially to medication(s)] or medical conditions your student has, and also of any medication(s) your student takes on a regular basis.
2. Restraint must be used by the school nurse in dispensing non-prescription medications. The student's complaint and symptoms must be assessed to determine if other measures can be used before medication is given.
3. All medications sent to school must be in the **original container,** and kept in the nurse's office. The only exception is for certain emergency medications. If your student has an emergency medication, the parent or guardian **MUST** make arrangements with the nurse.
4. Dosage and frequency for all medications is determined according to package directions, unless otherwise ordered by physician or other qualified healthcare provider. Medications administered by the school nurse may be name brand or generic equivalent.

By signing this document, I acknowledge that I have read and agree to the above statements. Furthermore, I give authorization for the school nurse to administer ONLY the medications I have checked above to my student.

_____ _____ _____

Parent/Guardian Signature *Phone (Daytime)* *Date*

DECLINE/REFUSE NON-PRESCRIPTION MEDICATIONS

I have read the above section and do not give my authorization for the school nurse to administer any of the above non-prescription medications to my student. I understand I may revoke this refusal in writing at any time.

_____ _____

Parent/Guardian Signature *Date*