

# Sturgis Charter Public School



An International Baccalaureate Diploma School

## SPECIFIC NON-PRESCRIPTION MED CONSENT FORM

*(to be completed by guardian)*

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Food/Drug Allergies \_\_\_\_\_

Current Medications \_\_\_\_\_

Health Concerns/ Diagnoses \_\_\_\_\_

The school nurse may assess and administer the following over-the-counter medications to my child during the school year:

- **Acetaminophen** (Tylenol 325 mg) 1-2 tablets every 4-6 hours as needed for minor pain, headache, etc.
- **Ibuprofen** (Advil/Motrin 200mg) 1-2 tablets every 6-8 hours as needed for minor pain, headache, muscle strain, menstrual cramps, etc.
- **Cough Drops** (generic brand) 1-2 as needed for minor throat discomfort or cough
- **Antacid Tablets** (Calcium carbonate 600mg) 2-4 tablets for relief of indigestion followed by a ½ glass of water

**I give permission to the School Nurse to share information relevant to the administered medication as she/he determines for my son's/daughter's health and safety.**

I GIVE CONSENT FOR MEDICATION ADMINISTRATION: \_\_\_\_\_ Yes \_\_\_\_\_ No

Parent. Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parents comments/instructions: \_\_\_\_\_

School Policy now requires a physician order for more than occasional use of analgesics (acetaminophen & ibuprofen) by the student during the school year. The school nurse will notify the parent/ guardian if their child requires an additional order from their primary care physician (PCP). In addition, the school nurse will forward this form to the PCP for signature should the need arise or the school nurse may determine that the more detailed consent and order form will need to be used. If excessive use of cough drops or antacids occurs the nurse will contact home and recommend a medical evaluation.

**I give the nurse permission to forward this form to my child's PCP in the event my son/daughter requires more than occasional use of analgesics as outlined in the school policy.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

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### PHYSICIAN ONLY

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional Orders: \_\_\_\_\_

