



MRH School District Health/Medication Information Form

Listed below are nonprescription medications that the nurses can give to students only with parent permission. We hope that using these medications, as needed, will reduce both absenteeism and student discomfort while in school. If a student needs routine medications, other arrangements should be made. Medications will be given in age/weight appropriate doses.

Please fill out this form, giving your permission for your child to get these medications if needed. It will become a part of his or her health file. **Check** the appropriate boxes and sign the bottom of this form, if you agree that your child may receive the following medications. Also, please note any medication allergies that your child may have. **No nonprescription medications will be given to students whose parents do not complete and return this form.**

My child may receive the following over-the-counter medications at school:

- Acetaminophen** (Tylenol) for headache and fever
- Ibuprofen** (Advil, Motrin) for muscle aches and pains, cramps, sinus pain
- Maalox** (or comparable nonprescription antacid) in liquid or tablet form for upset stomach
- Loratadine** (Claritin) for allergies and sinus
- Clotrimazole** as an antifungal for skin itch and rash
- Ocean Nose Spray** (or generic saline nasal spray) for stuffy nose or nasal dryness
- Natural tears** (or any saline eye drops) for eye dryness and/or itching
- Visine Allergy Eye Drops** for itching eyes
- Cough Syrup** (non-alcohol based, such as Robitussin) for dry coughs
- Calamine or Caladryl Lotion** (or generic) for itchy rash (not to be applied around the eyes)
- Benadryl** (Diphenhydramine HCL) for allergy symptoms
- Topical antibiotic ointment** for minor cuts and scrapes
- Topical Hydrocortisone Cream** for minor skin irritation and rashes (not to be used on the face)
- Benzocaine Sting Wipes** for insect bites and stings
- Oragel** (or generic equivalent) for temporary relief of mild toothache

PLEASE PRINT:

Student's Name _____ DOB: _____

Allergies _____

Age _____ Grade _____ School _____

Printed name of parent or guardian signing this form: _____

As the parent or legal guardian of the above named child, I give permission for the school nurse associated with the MRH School District to give the above named non prescription medications to my child for the conditions indicated.

Parent Signature _____

PLEASE FILL OUT FORM ON REVERSE

Parent(s)/Guardian(s) Contact

Parent/Guardian Name—(last, first)		
Parent/Guardian Relationship to Student: Mother Father Other	Student Lives With: Mother Father Other	
Parent/Guardian Current Address—City, State ZIP		
Home Phone	Cell Phone	
Parent/Guardian Employer	Parent/Guardian Work Phone	

Emergency Contact—In the event that either parent(s) or guardian(s) cannot be reached, the person listed below will care for your son/daughter and have permission to pick up the named student or be contacted in case of emergency.

Emergency Contact's Name—(last, first)	
Emergency Contact's Relationship to student	
Emergency Contact's Current Address—City, State ZIP	
Home Phone	Cell Phone
Emergency Contact's Employer	Emergency Contact's Work Phone
Doctor	Phone
Dentist	Phone
Preferred Hospital	Phone
Insurance	Plan #

Health History—Check if any of the following applies to your child.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Glasses/Contacts
<input type="checkbox"/> Seizures	<input type="checkbox"/> Had Chicken Pox	<input type="checkbox"/> Allergies	<input type="checkbox"/> Other
<input type="checkbox"/> If your child has other medical conditions/allergies please list them along with any medications your child is currently taking and the condition for which it is prescribed.			

Permission for Emergency Medical Care

I hereby give my permission to _____ (hospital of choice) to carry out those procedures, which their professional judgment deems necessary in the event that my child becomes involved in an accident or suffers from any physical condition that threatens life or physical ability during attendance in the MRH School District. I further give permission to the school personnel to help secure this care in the event I cannot be notified. I understand that expenses for ambulance or hospital are not the responsibility of the school.

Parent/Guardian Signature _____ Date _____

PLEASE FILL OUT FORM ON REVERSE