SUZY FISCHER
EARLY CHILDHOOD ACADEMY

MEDICAL AUTHORIZATION FOR OTC MEDICATION 2018-2019

Student's Name: _____ DOB: _____ Grade: _____
First and Last

Allergies: _____Student's Height: _____ Student's Weight: ____Kg/____Lb

TO BE COMPLETED BY LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER: This student may have the following Over the Counter (OTC) medications if needed during school hours. **All doses are per label instructions and stocked in the Health Office** (except for diaper creams).

MEDICATION	ROUTE	FREQUENCY	PERMISSION (MD)
A&D Ointment/Vaseline	Topical	p.r.n.	Yes____ No____
Acetaminophen – Child/Infant	p.o.	q4 p.r.n.	Yes____ No____
Anbesol (over 2 years old)	Topical	p.r.n.	Yes____ No____
Anti-itch Cream/Gel/spray	Topical	p.r.n.	Yes____ No____
Antibiotic Ointment (Neosporin)	Topical	p.r.n.	Yes____ No____
Arnicare	Topical	p.r.n.	Yes____ No____
Benadryl – Child	p.o.	q4-6 p.r.n.	Yes____ No____
Diaper Creams	Topical	p.r.n.	Yes____ No____
Hydrocortisone Cream	Topical	p.r.n.	Yes____ No____
Ibuprofen – Child/ Infant	p.o.	q6 p.r.n.	Yes____ No____
Normal Saline Eye Wash	Optical	p.r.n.	Yes____ No____
Pepto Bismol – Child	p.o.	p.r.n.	Yes____ No____
Solarcaine	Topical	p.r.n.	Yes____ No____
Suntan Lotion	Topical	p.r.n.	Yes____ No____
Tums – Child	p.o.	p.r.n.	Yes____ No____

Prescription Medication or OTC medication not listed on this form to be given at school:

MEDICATION	DOSAGE	FREQUENCY	SIDE EFFECTS

SPECIAL INSTRUCTIONS:_____.
List health care procedures the student may independently monitor (inhalers, insulin, epi pens)_____
_____

_____ _____
Physician's Name (Printed) **Physician's Address**

_____ _____
Physician's Signature **City/State/Zip Code**

_____ _____
Date Completed **Physician's Telephone Number**

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EARLY CHILDHOOD ACADEMY

PARENT/GUARDIAN PERMISSION FOR TREATMENT and/or MEDICATION 2018 - 2019

During the school day, medication is to be dispensed only by the Health Office nurse or her designee. For a prescribed medication to be dispensed, medication must be supplied by the parents in the original container, with the pharmacy label, only with a physician prescription, and an Authorization For Administration of Prescription Medication must be completed, signed and on file in the Health Office. NO MEDICATION (OTC or Prescription) WILL BE DISPENSED WITHOUT A PRESCRIPTION FROM A PHYSICIAN (on a Suzy Fischer Form). If a child uses insulin, an asthmatic inhaler, or needs an epi pen and wants to carry this medication with him or her, a physician order with instructions for use and parameters must be on file in the Health Office.

I hereby authorize the Suzy Fischer Early Childhood Academy, through its designated authority (school nurse/head of school or her designee), to assist or perform the administration of each medication or treatment/procedure to or for my child during the school day including when he/she is away from school property for official school events (day field trips). This includes over-the-counter medications and prescription medications or treatments to my child according to the instructions given by a physician. Although medical information about your child will be kept confidential, I understand that the information concerning my child's medical condition will be provided to all applicable school personnel and administrators to facilitate awareness and proper medical care throughout the day. I release Suzy Fischer Early Childhood Academy and any employee from any liability for administering medication or treatment.

NOTE:

- **Prescription medications must be supplied in the original pharmacy labeled container. Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.**
- **The school nurse and/or her designee may administer only medications and/or treatments authorized by a physician. No medication will be given without a physician order on the Authorization for Administration of Prescription Medication form.**
- **It is your responsibility to notify the school when there is a change in medication or treatment regimen.**
- **Over the counter medication will only be given with a signed Medical Authorization for Over the Counter Form by a licensed physician**

I understand that if my child requires antibiotics, I will be responsible to administer them at home. If a dose must be given during school hours, the child's pediatrician must complete an **Authorization for Administration of Prescription Medication** form which can be found on the school website at www.btbrc.org/eca

_____ _____

Parent/Guardian Name (Printed) Parent/Guardian Signature

_____ _____

Student Name Date Signed