**Meadow Glade Adventist Elementary School**
**2023-2024**
**Authorization for Administration of Non-Prescription Medication at School**

| Student Name: | | Birth Date: |
|---|---|---|
| Allergies: | Grade: | Teacher |

I give the School Nurse (or designated staff) of Meadow Glade Adventist Elementary School permission to administer the following medication(s) at her discretion for the temporary relief of discomfort associated with a cold, fever, headache, dental discomfort, muscular aches, premenstrual or menstrual pain, sore throat, upset stomach, allergic reactions, rashes due to Poison Ivy, Oak or sumac, coughs, cuts, and scrapes.

**Please check any medication you wish to be made available to your child**

| | |
|---|---|
| _____ Acetaminophen (like Tylenol | 10-15 mg/kg per dose every 4 hours as needed |
| _____ Ibuprofen (like Advil) | 10 mg/kg per dose every 4-6 hours as needed |
| _____ Diphenhydramine HCL (like Benadryl) | Ages 6-12: 12.5-25mg every 4-6 hours as needed |
| _____ Ointment (Bacitracin, Neomycin) | Small amount to cover cuts and scrapes as needed |
| _____ Anti-itching lotion (like Calamine) | Apply to affected area every 4 hours as needed |
| _____ Chewable antacid tablets (like Tums) | 1-2 tablets every 4 hours as needed |
| _____ Cough drops (like Halls or Ludens) | As needed for coughing |

- I hereby give my permission for the above-named student to receive any medication listed above as deemed necessary by the school nurse. I have checked those medication(s) I wish to be made available to my child.
- I request that authorized school staff assist my child in taking the oral medication(s) described above.
- I understand that school staff will attempt to administer medication in a timely manner.
- I understand that only a registered nurse may apply any ointment to my child's cuts/scrapes/rashes.
- I will provide the oral medication in the original, properly-labeled container.
- I give my permission for the exchange of information between the school staff and health care provider.
- I understand that only these medications and doses listed will be administered. If my child needs additional medication or a different dose, my child will need a separate order (on the Prescription Medication Administration form) signed by a health care provider.
- I understand my signature indicates my understanding that school staff shall not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and in accordance with school policy and Washington State Law (RCW 28A.210.260).

****THIS PORTION MUST BE COMPLETED BY THE HEALTH CARE PROVIDER****

I authorize that the above-named student be administered the above-identified medication(s) in accordance with his/her parent/guardian's request, and according to instructions indicated above from _____ to _____ (not to exceed the current school year).

_____ _____
**HEALTH CARE PROVIDER SIGNATURE** **DATE**

_____ _____
Print Name Phone Number

_____ _____
**Parent/Guardian Signature** Date

Home Phone number:_____ Cell/work number_____

February 2023