LEARNING FIRST CHARTER PUBLIC SCHOOL

Krista Piazza,
Superintendent
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PARENT/GUARDIAN AUTHORIZATION FOR OVER THE COUNTER MEDICATION AND TREATMENT

Students Name: _____ Date of Birth: _____

Food & Drug Allergies: _____

Daily medications taken by the student:_____

Parent/Guardian Name: _____
Home Phone Number: _____
Cell Phone Number: _____
Work Number: _____

Emergency Contact:_____ Phone Number:_____

I give consent for my child to receive the following medications at school. I understand that in the event of a field trip, a non-licensed staff member may administer the medication: **(please check the medication(s) that can be given to your child)**

Acetaminophen (Tylenol)	**Ibuprofen (Advil/Motrin)**
Calamine lotion	**Topical antibiotic ointment**
Hydrocortisone cream	**Diphenhydramine HCL (Benadryl)**
Eucerin	**Aloe vera gel**

Dosages of acetaminophen and ibuprofen will be given according to students weight

I consent to have the school nurse or school personnel designated by the school nurse administer the over the counter medication. _____ YES _____ NO

I understand this consent is good for the current school year only.

Parent/Guardian signature:_____ Date:_____