School Year 20___ - 20___

MORNING STAR CHRISTIAN SCHOOL

STUDENT MEDICATION FORM

Student Name:___________________________________ Grade: ___________ Birth Date: ___________

Mother's name: ____________________________________ Daytime Phone Number: ___________________

Father's name: _____________________________________ Daytime Phone Number: ___________________

Emergency Contact Name: ___________________________ Daytime Phone Number: ___________________

Known medical conditions or special needs: ____

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Known allergies: ____ Child Weight: _____________

Morning Star Christian School may administer the following medications to my child for the purposes listed and at intervals and in dosages suggested by the manufacturer:

***Acetaminophen** (Tylenol) may be given for headache, toothache, cramps, earache and muscle ache

☐ Acetaminophen - 80 mg ☐ Acetaminophen - 160 mg ☐ Acetaminophen - 500 mg

***Ibuprofen** (Advil, Motrin) may be given for cramps, muscle ache, headache, backache, toothache

☐ Ibuprofen – 100 mg ☐ Ibuprofen – 200 mg

***Meclizine** (Bonine) may be given for motion sickness

☐ Meclizine – 25 mg.

***Antacid** (Tums, Rolaids) may be given for upset stomach or heartburn

☐ Antacid– 750 mg. – 1-2 tablets

☐ ***Topical creams** such as Benadryl, insect relief, etc, may be applied for allergy related symptoms, insect bites, minor skin irritations or burns

Please administer the above medications as needed and according to the manufacturer suggested dosages for my child, _______________________. I agree the information on this form may be shared with school personnel as needed. This permission is in effect for the current school year. If any information in this form is to change, I will submit a new completed form to the school office.

I understand that all prescription medication, any medication (including cough drops) not specified on this form, *and* any ongoing over-the-counter medication *will be provided by me* in the original container, clearly labeled with my child's name. I will fill out a special request medication form for any such medication I send for my child, and my child will not keep the medication with him/her. I will be responsible for noting the expiration date of all medication. Expired medication will not be given at school. All medication should be picked up by the last day of school. I understand that any over-the-counter medication given for 10 consecutive days must also have a physician's authorization.

I will notify the school of any change of information in this form, including notifying the school if any of my child's medication is discontinued or if the dosage is changed.

Parent Signature: ____ Date: ________________________