
MEDICATION PERMISSION FORM

Dear Parent or Guardian:

State law prohibits the school from dispensing any form of internal medication to students, unless we have parental permission. The following medications are kept in the school office. Please check option below, then fill out bottom portion accordingly

[] I, _____, give my permission to allow the Arcadia Public School to dispense the medications INDICATED BELOW to my son/daughter,

[] I _____, DO NOT wish you to dispense any medications of any form to my son/daughter, _____

Check medications your child may receive and fill out the dosage and time interval that the product is to be given.

Table with 3 columns: MEDICATION, DOSAGE, INTERVAL. Rows include Non-Aspirin Pain Reliever - Jr. Strength chewable, Ibuprofen-Jr Strength, Extra-Strength Non-Aspirin, Ibuprofen, Pamprin/Midol Tablets.

If a child is currently taking a prescription medicine or other medicine, the medicine should be kept in the office during school hours and administered by office staff. Please call if any questions.

ASTHMA/ANAPHYLAXIS PROTOCOL

This protocol, Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis), trains non-medical school staff to identify a "breathing emergency" and respond by calling 911 and administering EpiPen followed by nebulized albuterol. All emergency responders are trained in CPR.

Directions: Please write your child's name on the blank line. Check any items that apply to your son or daughter. Sign and date the lines provided and return to the school.

CHILD: _____ Grade: _____

[] No My Child does not have Asthma/Anaphylaxis Needs
[] Yes My Child have Asthma/Anaphylaxis needs with the following requirements:
Inhaler Use [] EpiPen Use [] Nebulizer Use [] Diabetic

**ALL STUDENTS IDENTIFIED AS HAVING ASTHMA MUST HAVE AN ASTHMA ACTION PLAN ON FILE WITH THE SCHOOL NURSE. (Must be renewed annually.)

Signed: _____ Date: _____