



# Delmarva *Christian* High School

2011-2012

Request to have medication / treatment administered in school

**Student Name:** \_\_\_\_\_ **Allergies** \_\_\_\_\_

The following medications / treatments are available in the nurses office, please check what your child may have:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> cough drops       | <input type="checkbox"/> sore throat spray        | <input type="checkbox"/> antifungal ointment        |
| <input type="checkbox"/> throat lozenges   | <input type="checkbox"/> Anbesol                  | <input type="checkbox"/> Neosporin ointment         |
| <input type="checkbox"/> sun screen        | <input type="checkbox"/> Campho-phenique gel      | <input type="checkbox"/> Triple Antibiotic ointment |
| <input type="checkbox"/> Benadryl topical  | <input type="checkbox"/> white petrolatum topical | <input type="checkbox"/> sunburn topical relief     |
| <input type="checkbox"/> Calamine lotion   | <input type="checkbox"/> rubbing alcohol          | <input type="checkbox"/> Hydrocortisone Cream       |
| <input type="checkbox"/> Caladryl lotion   | <input type="checkbox"/> hydrogen peroxide        |   |
| <input type="checkbox"/> First Aid cream   | <input type="checkbox"/> Ammonia Inhalants        |   |
| <input type="checkbox"/> sterile eye drops | <input type="checkbox"/> sting kill topical       |   |

The following over the counter or prescription medication / treatment (provided by the student) may be administered in school according to the medication policy and procedure.

<u>NAME</u>	<u>DOSE</u>	<u>TIME</u>	<u>REASON</u>
IE: Tylenol	325 mg two pills	as needed	for headache, menstrual cramps, temperature

Physician Signature: \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_

Parent / Guardian signature: \_\_\_\_\_  
 Date \_\_\_\_\_  
 Phone \_\_\_\_\_

***BOTH PHYSICIAN AND PARENT SIGNATURE REQUIRED***