



# Summer MEDICATION REGISTRY 2023

Due: May 19th

Student:            Mr.   Miss   (Circle One)

Last

First

Middle

Preferred

## Over-the-Counter Medications

All over-the-counter, prescription medications and supplements must be supplied by parent/guardian and will be maintained in the Health Office. Please note ALL medications must be in their original container and will be labeled with your child's name.

Please Place Your Initials in the Block Beside the Medicine Your Child May Have At School

Over-The-Counter Medication/Supplement	
Naproxen (i.e., Aleve)	
OTC Migraine Medication (i.e., Excedrin)	
Acetaminophen (i.e., Tylenol)	
Ibuprofen (i.e., Motrin)	
Diphenhydramine Hydrochloride (i.e., Benadryl)	
Loratadine (i.e., Claritin)	
Multi Symptom Cold Medication (i.e., DayQuil)	
Cough Expectorant/Suppressant (i.e., Mucinex)	
Decongestant (i.e., Sudafed)	
Stool Softener/Laxative (i.e., Dulcolax)	
Stomach Medication (i.e., Pepto-Bismol/ Milk of Magnesia)	
Meclizine Hydrochloride (i.e., Dramamine/ Bonine)	
Menstrual Cramp Medication (i.e., Pamprin)	
Other OTC:	
Other OTC:	
Other OTC:	

I give permission for medications checked above to be given,  
 as needed per package directions.

Parent/Guardian Signature

Date

# Summer MEDICATION REGISTRY 2023

Student:

---

Last

First

Middle

Preferred

## Permission/Authorization for Prescription Medications to be given at school

Medication	Dose	Frequency	Parent/Guardian's Initial	Physician's Initial

I give permission for my child to be given the above medication as prescribed. I give permission for the school nurse or a school administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child's health to the school nurse or school administrator. I understand that I am responsible for notifying the school if my child's medications change in any way. I understand this medication must be kept in the SCGSAH Health Office. **Note: Please contact the school nurse for a self-administration permission form for birth control pills, asthma inhalers, insulin and EpiPens.**

### Signature of Parent/Guardian

---

Signature

Date

### Physician Completing Form

(All information must be provided.)

Physician's signature required only if there are prescription medications.  
Please list and initial all prescription medications ordered for administration.

---

Physician's Name Printed

Physician's Signature

---

Practice Name

Date Exam Completed

---

Mailing Address

City

State

Zip

---

Telephone Number

Fax Number