Christian Academy
Medication Permission

Entering Grade______
School Year________

Student's Last Name________________First Name_____________Middle Name__________

DOB______________ Emergency Contact __________________ phone _________________

Allergies______________________________________

I,__________________,hereby give Christian Academy permission to administer the following over-the-counter medications, or suitable generic substitute, to the above student, if the medical staff deems necessary. Dosages will be administered according to directions on the bottle. I hereby certify that my child has not in the past shown any allergic or other adverse reaction to any of the medications which you are hereby authorized to administer. **Please cross through any medications that you do not approve for use with your child.**

For:	Use:
Headache, general pain	Tylenol, Advil
Upset Stomach	Pepto Bismol, Imodium, Tums
Menstrual Cramps	Midol, Advil
Rash/Itching/Hives	Benadryl, Hydrocortisone cream
Cough/Sore Throat	Robitussin, Delsym, Cough Drops
Sinus Headache/Congestion	Mucinex Cold Relief, Dimetapp Cold
Sunburn	Aloe Vera
Bee Sting	Sting Relief
Cuts/Scrapes	Peroxide, Antibiotic Ointment
Toothache/Sore gums	Orajel, Anbesol

Christian Academy will have a small stock of these medications. If you know your child will take any of these medicines on a regular basis (more than twice per month) please provide a supply.

I acknowledge that there is a risk of complications and unforeseen consequences in any medical treatment. I acknowledge that no warranty is being made as to the result of any medical treatment.

Parent/Guardian Signature _________________________ Date___________