BAKERSFIELD R-IV SCHOOL DISTRICT

HEALTH INFORMATION AND OTC MEDICATION CONSENT 2023-2024

STUDENT: _____ DOB: _____ GRADE: _____

FAMILY PHYSICIAN: _____ Phone: _____

PLEASE LIST ANY MEDICAL CONDITION YOUR CHILD HAS and DATE OF DIAGNOSIS:

_____

_____

CURRENT MEDICATIONS: _____

PRESCRIPTION MEDICATION:

PRESCRIPTION MEDICATION MUST BE BROUGHT TO THE SCHOOL IN THE LABLED PRESCRIPTION BOTTLE WITH A CURRENT DATE. A CONSENT FORM MUST BE SIGNED BEFORE MEDICATION WILL BE GIVEN AT SCHOOL. THE FIRST DOSE OF MEDICATION WILL NOT BE GIVEN AT SCHOOL. If antibiotics must be given at school, please have the pharmacy label a bottle for school. Medication should not be transported to and from school daily.

Students are allowed to carry their inhalers and Epi-pens **WITH written physician order** stating that they need to keep it with them at all times and that they have been properly instructed on how to use

Allergies: _____

Reaction the allergy causes: _____

Does the allergy require the use of an Epi-Pen? _____

I Authorize health information to be shared between my child's health provider and school health service staff as needed. I understand the information given will be shared with appropriate school staff for my child's health and safety at school. In the event of an emergency situation in which I or my emergency contacts cannot be reached, I authorize the Bakersfield school staff to send my child to the nearest medical facility or physician. I understand that I will assume full financial responsibility for any transport or emergency medical services rendered. I release Bakersfield R-IV School District from any liability related to the administration of medication or treatment so long as reasonable and customary care are provided.

_____ _____

Parent Signature Date

Please complete back of form for OTC medication administration

Over the counter medication will be administered with signed parental consent. Over the counter medication will not be given on a daily basis, or in excess of recommended manufacturer's dosage, unless a signed physician statement with current date is given to the school with the ordered dosage.

The following over the counter medication will be given at school with parental permission. Please mark the OTC medication that you give permission for school staff to administer to your child, if needed while at school.

____ Acetaminophen (Tylenol)

____ Ibuprofen

____ Antihistamine (Benadryl, Zyrtec, Claritin)

____ Pepto Bismol

____ Antiacid (Tums)

____ Benadryl cream

____ Hydrocortisone cream

____Triple antibiotic ointment

____Antifungal cream (ringworm)

____Burn cream or Aloe gel

____ Eye drops

____Oral Gel

____Cough drops

____ Bio Freeze or muscle rub

_____ _____

Parent Signature Date

Please list any other health concerns you may have for your child: _____

_____