

West Plains School District Medical Consent Form

Name _____ Birthdate _____ M ___ F ___ Grade _____

Parent/Guardian _____ Home Phone _____ Work Phone _____

Emergency Contact _____ Home Phone _____ Work Phone _____

Additional Phone Numbers _____ Family Doctor _____

Drug/Food Allergies (Be Specific) _____

Significant Health Problems _____

Medications Taken at Home _____

The West Plains School District has my permission to administer the following Over-the-Counter medications checked:

___ Acetaminophen for temperatures, general discomfort- (not to exceed one dose per day)-
(80mg) Grades Pre-K-2 four tablets, (325mg) grades 5-8 one tablet, grades 9-12 two tablets

___ Antacid regular strength for upset stomach/heartburn (not to exceed one dose day)

___ Chloroseptic spray for sore throat, Canker sores, minor irritations gums/mouth (3)
Sprays for PK-8 (5) for 9-12 (may repeat every two hours)

___ Anbesol for toothache pain, cold sores (may repeat two hours as needed)

___ Camphopenique for insect bites/chapped lips (not to exceed twice daily)

___ Sting kill swabs for insect bites/bee stings

___ Calamine Lotion or irritated/itching skin (not to exceed twice daily)

___ Clean Abrasions/Wounds with soap and water/Hydrogen Peroxide-Apply
Antibiotic Ointment

___ Benadryl 12.5 mg benadryl FOR ALLERGIC REACTIONS ONLY!

___ Cough Drop (one given per day) *

Parent/Guardian Signature _____ Date _____

West Plains School District has my permission to administer the following medication:

Medication _____ Amount to give _____

Doctor Prescribing _____ Time to give _____

Reason taking medication _____

Parent/Guardian Signature _____ Date _____

*** For medications to be given you must follow the medication protocol outlined in the Handbook and attached to this note, or they will not be given. ***

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