

MIFFLIN COUNTY SCHOOL DISTRICT

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Dear Parents:

The following list of non-prescription medicines and first aid materials may be given to your child for minor complaints and/or ailments while in school. The administration of these items is intended for first aid only and is not indiscriminately dispensed. When an elementary school student is administered Item #1, (Tylenol), on the list of medicines listed below during school hours; you will be notified by the school. There are parents who may not wish some, or all, of these items to be given to their child. If you object to any item(s) on the list, please indicate so on this form. If you approve all medications, please indicate in the appropriate space below. Return this form to school as soon as possible.

- #1 - TYLENOL (age/weight appropriate dose - chewable available)
- #2 - CHLORASEPTIC SPRAY (for sore throat, fever blisters, gum discomfort)
- #3 - BACTINE SPRAY (for minor cuts or abrasions, after using soap and water to cleanse the area)
- #4 - BACITRACIN ANTIBIOTIC OINTMENT (apply locally when needed)
- #5 - CALAMINE OR ZIRADRYL LOTION (apply locally for poison ivy and hives)
- #6 - STING-KILL SWAB (to be used on insect bites)
- #7 - DACRIOSE EYE IRRIGATING SOLUTION (for dust in eye, etc.)
- #8 - MENTHOLYPTUS COUGH DROPS (for coughs and stuffy noses)
- #9 - BENADRYL (for allergic reaction)

(Complete this portion and return it to school as soon as possible.)

I DO NOT WISH MY CHILD TO BE GIVEN ANY OF THE ITEMS CHECKED BELOW:

- | | |
|--|--|
| <input type="checkbox"/> #1- <u>TYLENOL</u> (age/weight appropriate dose-
chewable available) | <input type="checkbox"/> #5- <u>CALAMINE OR ZIRADRYL LOTION</u> |
| <input type="checkbox"/> #2- <u>CHLORASEPTIC SPRAY</u> | <input type="checkbox"/> #6- <u>STING-KILL SWAB</u> |
| <input type="checkbox"/> #3- <u>BACTINE SPRAY</u> | <input type="checkbox"/> #7- <u>DACRIOSE EYE IRRIGATING SOLUTION</u> |
| <input type="checkbox"/> #4- <u>BACITRACIN ANTIBIOTIC OINTMENT</u> | <input type="checkbox"/> #8- <u>MENTHOLYPTUS COUGH DROPS</u> |
| | <input type="checkbox"/> #9- <u>BENADRYL</u> |

MY CHILD MAY BE GIVEN ANY OF THE ITEMS LISTED ABOVE.

My child must/may take the medication specified above. The school nurse or designated school official has my permission to dispense this medication to my child. As parents/guardians of the child named below, I/we release the Mifflin County School District and its employees or agents from any and all liability for any injuries my child may suffer as a result of this request.

_____	_____	_____
(Student's Name)	(School)	(Grade)
_____		_____
(Parent /Guardian Signature)		(Date)

(Rev.1/09) (AN EQUAL OPPORTUNITY EMPLOYER TITLE IX 1972 EDUCATIONAL AMENDMENT)

Mifflin County School District complies with all federal HIPPA regulations. No health information is released without signed authorization of the parent or legal guardian.