CINCINNATI COUNTRY DAY SCHOOL

6905 GIVEN ROAD, CINCINNATI, OHIO 45243
SCHOOL NURSE PHONE: (513)979-0250

OVER THE COUNTER MEDICATION ORDERS FROM PHYSICIAN

Return this form ***ONLY IF*** your child ***might*** need to take over the counter medication during school hours, overnight field trips, or sports activities. **Medications will not be administered unless there is a medication order on file signed by the physician and parent/guardian.**

STUDENT NAME & ADDRESS	GRADE/DIVISION 2023-2024	DATE OF BIRTH	DURATION
			BEGINNING: _____ ENDING: _____

These are the current stock medications available in the Nurses' Office

Acetaminophen (i.e. Tylenol) – PRN; every 4-6 hours for minor discomforts associated with headache, fever, or muscle pain.

_____ 24-35 lbs/ 2-3 yrs.-160 mg _____ 60-71 lbs/9-10 yrs.-400mg _____ 96 lbs & over/12 yrs. & older- 650 mg

_____ 36-47 lbs/4-5 yrs.-240 mg _____ 72-95 lbs/11 yrs.-480 mg

_____ 48-59 lbs/6-8 yrs.-320 mg _____ 96 lbs & over/12 yrs. & older -325 mg

Ibuprofen (i.e. Motrin, Advil) – PRN; every 6-8 hours for minor discomforts associated with headache, fever, or muscle pain- given w/ food

_____ 24-35 lbs/2-3 yrs.- 100 mg _____ 60-71 lbs/9-10 yrs.- 250 mg _____ 96 lbs & over/12 yrs. & older – 400 mg

_____ 36-47 lbs/4-5 yrs.-150 mg _____ 72-95 lbs/11 yrs – 300 mg

_____ 48-59 lbs/6-8 yrs. -200 mg _____ 96 lbs & over/12 yrs. & older – 200 mg

Calcium Carbonate 750 mg (i.e. Tums) – PRN for upset stomachs and indigestion; once per day at school

_____ 1-2 chewable tablets _____ 2-4 chewable tablets

Diphenhydramine HCL (Benadryl) – PRN; every 4-6 hours for symptoms associated with upper respiratory allergies and common cold

_____ 48-95 lbs/6-11 yrs.-12.5-25 mg _____ 95 lbs & over/12-18 yrs.- 25-50 mg

Loratadine 10 mg (Claritin) - PRN; 1 tablet every 24 hours for symptoms associated with upper respiratory allergies.

_____ 48 lbs & over/6-18 yrs.

First Aid Items for PRN use

_____ Triple antibiotic ointment for minor wounds (apply 1-3 x daily) _____ Calamine lotion for poison ivy (apply 3-4 x daily)

_____ Caladryl Clear for itching from insect bites (apply 3-4 x daily)

_____ 1% Hydrocortisone cream for itching from insect bites, rashes (apply 3-4 times daily)

Signature of Physician (*REQUIRED*): _____ **Physician ER Phone:** _____

Physician Name *(Print)*: _____ **Date:** _____

PARENT PERMISSION

I, _____, the parent or guardian of _____ gives permission for the medication ordered by the above physician to be given at school. I further agree to:

Not file or make any claim against anyone for negligence in connection with the administration or non-administration of any medicines and further agree to save such individuals and hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines. I give my permission for the Head of School or his/her designee to administer the prescribed medication. I have read the Guidelines for Administration of Medication at School and will abide by them.

Parent/Guardian Signature ***(REQUIRED)***: _____ Phone: _____ Date: _____

NO MEDICATION WILL BE GIVEN WITHOUT A DOCTOR'S ORDER /ORDERS EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR