CESJDS
CHARLES E SMITH JEWISH DAY SCHOOL
בית מדרש צוריאל

Student Name: _____

Grade: _____

Non-Prescription Medication Authorization 2015-2016

(REQUIRED FORM FOR ALL STUDENTS)

PLEASE NOTE: Medications may only be given if this form is signed by BOTH the physician and parent.

Please sign here if you DO NOT wish to have any medications administered to your child at school.

Parent Signature _____ **Date** _____

Please **INITIAL** next to the name off ALL medications that you will allow to be administered to your child if warranted.

Non-prescription medications and topical preparations that are provided in the health room:
(Generic forms may be substituted when available)

_____ Tylenol

_____ Advil

_____ Excedrin Migraine

_____ Benadryl *(allergic reactions)*

_____ Neosporin *(prevent infection)*

_____ Cortisone cream *(itching/inflammation)*

_____ Dermoplast *(bug bites, sunburn and rashes)*

_____Claritin

_____ Tums *(indigestion)*

_____ Lactaid

I hereby request and authorize the Charles E. Smith Jewish Day School nurse to administer the non-prescription medications initialed above as deemed appropriate by the school nurse. I agree to release, indemnify and hold harmless CESJDS and any of its officers, staff members or agents from lawsuit, claim, demand or action, etc. against them for administering these medications to this student, provided CESJDS staff administer dosage according to manufacturer's recommendations or physician's orders. I have read the procedures outlined and assume responsibilities as required.

*** Parent Signature** _____ **Date** _____

TO BE COMPLETED BY PHYSICIAN:

I give permission for the above student to receive the initialed medication.

Physician Name _____

*** Physician Signature** _____ **Date** _____

Please return all forms to your child's campus:
Lower School: 1901 E. Jefferson St., Rockville, MD 20852 **Fax**: 301-984-7834
Upper School: 11710 Hunters Lane, Rockville, MD 20852 **Fax**: 301-230-1986
Attention: School Nurse