

POLICY FOR ILLNESS AND MEDICINE DISTRIBUTION
2008-2009

The following symptoms will describe our decision to send your child home from school. If your child has fever, vomiting, diarrhea, moderate to severe pain, or head lice, we will contact you to come get your child. He or she will need to return to school ONLY after being free from symptoms for 24 hours. Please complete the following.

CHILD'S NAME _____

Phone number(s) most likely to reach you _____

Please provide the name and number of 3 people who can get your child if you are unable to be reached. (Can be spouse, grandparent, friend, etc.) Let them know you have put their name on the list of possible contacts.

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Listed below are the medications we can administer in the event of mild pain, cold symptoms, itching, or small cuts and scrapes. Your signature gives us permission to administer the medications checked. All medications will be given according to package directions. Please check the ones your child CAN be given.

Acetaminophen(Tylenol)_____

Ibuprofen(Motrin)_____

Antiseptic/Analgesic Spray_____

Diphenhydramine (Benedryl)_____

Diphenhydramine/Phenylephrine (Allergy/Sinus medication)_____

Neosporin(topical antibiotic)_____

Antacid(Tums)_____

Stomach Relief (Pepto)_____

Cough Drops _____

Please **do not** give my child **any** medication _____

PARENT

SIGNATURE _____ DATE _____