PIMA UNIFIED SCHOOL DISTRICT
OVER-THE-COUNTER MEDICATION CONSENT

Please check the medications you want your child to receive if the need arises during the school day. If your child needs prescription medication at school, it must be brought in by the parent in the original container, and a different form needs to be completed.

☐ Acetaminophen (Tylenol) tablets

☐ Pseudoephedrine (Sudafed) decongestant tablets

☐ Cough Drop / Throat Lozenge

☐ Antacid (Mylanta) chewable tablets or caplets

☐ Topical medication (orajel for sore gums, triple antibiotic ointment for minor scrapes and cuts, caladryl lotion for relief of itching skin, and burn spray for pain relief of minor burns.)

Student's Name: _____ DOB: _____ Grade: _____ Teacher: _____

Mother's Name: _____ Home #: _____ Work/Cell#: _____

Father's Name: _____ Home #: _____ Work/Cell#: _____

Child lives with: _____

Home mailing address: _____

List three individuals that the school may contact if unable to reach you in case of any illness or emergency. Please be aware that under any circumstance your child may only be released to these individuals unless notified by the parent/guardian.

1. _____ Phone #: _____ Relationship to child: _____

2. _____ Phone #: _____ Relationship to child: _____

3. _____ Phone #: _____ Relationship to child: _____

Your current family doctor: _____ Dentist: _____

Consent for Emergency Care

I give permission to the Pima school nurse, qualified school officials, medical physician or hospital my consent and authorization to render medical aide or treatment to the above named student in the case of an emergency occurring during the school day or during a school sponsored activity. I also understand and acknowledge that every attempt possible will be made to notify myself and the above listed emergency contacts should such an emergency arise.

_____ _____

Signature of parent or legal guardian Date

Please fill out health information on back.

MEDICAL HISTORY

Please answer yes or no as it pertains to your child. If answering "yes" please fill in the date the problem started.

YES	NO	MEDICAL CONDITION	DATE	FAMILY HISTORY	COMMENTS
☐	☐	Allergies: Seasonal, food, medication, other (Circle what applies and list specific allergies in comments.)			
☐	☐	Asthma			
☐	☐	Diabetes			
☐	☐	Seizure Disorder			
☐	☐	Heart Condition			
☐	☐	Tuberculosis			
☐	☐	Valley Fever			
☐	☐	Birth Defects			
☐	☐	Kidney Disease			
☐	☐	Attention Deficit Disorder/Hyperactivity			
☐	☐	Chicken Pox (MUST list month/year)			
☐	☐	Glasses/Contacts			
☐	☐	Hearing Impairment			
☐	☐	Other			

Please list any medications that your child takes for any of the above conditions or for anything else.

_____

_____

If your child should have any significant health changes please notify the school nurse.