

Requirements for administration of  
**Non-Prescription Medication**

Reference: ARS 15-344

Student Name: _____ / _____ - _____ - _____ / _____			
Last	First	Student's Date of Birth	Grade for 2009-2010

Dear Parent/Guardian:

You **MUST** read the Medication Distribution section in the Handbook each year. No medication will be distributed by any CCS personnel unless the legal and required procedures are followed by the parent/guardian.

<b>My child may receive the Non-Prescription/Over-the Counter medication(s) indicated below that I have provided in the original container:</b>			
<b>Authorization</b> Check Yes or No	<b>Medication</b> Circle those that apply	<b>Dosage</b> Please note	<b>Frequency</b> Please note
Yes ( ) No ( )	Tylenol, Motrin, Ibuprofen	One (1) Adult Regular Strength	
Yes ( ) No ( )	Children's Chewable Tablets Tylenol, Motrin, Ibuprofen	Children's Strength	
Yes ( ) No ( )	Benadryl		
Yes ( ) No ( )	Tums		
Yes ( ) No ( )	Mylanta		
Yes ( ) No ( )	Pepto Bismol		
Yes ( ) No ( )	Cough Drops, Throat Lozenges		
Yes ( ) No ( )	Cold Syrup		
Yes ( ) No ( )	Other		

**Please, continue on reverse side. . .**

**If your child incurs a cut or scratch while on campus:**

Can the school administer Hydrogen Peroxide to cleanse the cut or scratch?	(    ) Yes	(    ) No
Can the school administer Neo-Sporin (or other Anti-Biotic Ointment) to the cut or scratch once it has been cleansed?	(    ) Yes	(    ) No

**If your child has itching skin while on campus:**

Can the school administer Calamine Lotion to irritated/itching area?	(    ) Yes	(    ) No
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**Allergic Reactions:**

Please list and explain any reactions to food, medicine, insects, etc.

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**Please write any other additional instructions below:**

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**I authorize the school nurse/health aid or designee to be my agent for the entire time that my student is enrolled at Challenge Charter School and to give to my child the medication(s) that I have noted above. I understand that it is my responsibility to notify the School of any updates/changes to my child's medical information or if I would like to add or remove any medications that my child is authorized to receive at school.**

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**Signature of Parent/Guardian** **Date**