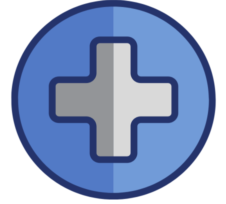
Little Chute Area School District
Health Services
STOCK MEDICATION ADMINISTRATION



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Elementary Fax: 920-788-7847 AND IM/MS/HS Fax: 920-788-7841

The following stock medications are available to all LCASD students in grades 5-12 from 7:30-3:30 pm and are offered as a courtesy to students and parents/guardians. Stock medications will be given as directed on the package.

STUDENT INFORMATION

STUDENTS NAME:	**DOB**:	**GRADE:**
SCHOOL ATTENDING:		

STOCK MEDICATION APPROVALS

NAME OF MEDICATION	***PURPOSE***	***DOSE***	***FREQUENCY***	***APPROVED*** *(YES OR NO)*	
Acetaminophen 325 mg each tablet *(Regular Strength)*	To treat mild to moderate pain *(from headaches, menstrual periods, toothaches, backaches, osteoarthritis, and/or pain)*	1-2 tablets (325-650 mg)	Every 4 to 6 hours as needed not to exceed 10 tablets in 24 hrs.	YES	NO
Ibuprofen 200 mg each tablet	To treat mild to moderate pain *(from headaches, menstrual periods, toothaches, backaches, osteoarthritis, and/or pain)*	1-2 tablets (200-400mg)	Every 4 to 6 hours as needed not to exceed 6 tablets in 24 hrs.	YES	NO
Benadryl 25mg each tablet	Relief of symptoms of allergies or hay fever *(Symptoms include; runny nose, sneezing, itchy, watery eyes, and itching of the nose or throat)*	1-2 tablets (25-50 mg)	Every 4 to 6 hours as needed not to exceed 6 tablets in 24 hrs.	YES	NO
Tums 750mg each tablet *(Extra Strength)*	Relief of heartburn, acid ingestion, sour stomach & upset stomach associated with these symptoms.	2-4 tablets (1500-3000mg)	As needed. Not to exceed 10 tablets in 24 hours.	YES	NO
Cough Drops Menthol 7.5 mg	Relief of temporary irritation or sore throat	1 cough drop	Every 2 hours as needed.	YES	NO
Benadryl Cream	Relief of pain and/or itching	Topical	As needed.	YES	NO

☐ I certify my child has no known allergies to the above “YES-circled” approved medications.
☐ My child is known to be allergic to the following medications: ____

AUTHORIZATION

PARENT/GUARDIAN MEDICATION CONSENT

I hereby give permission to designated school personnel to give medications to my child during the school day, including when away from school property on official school business. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication(s) administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District and LCASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.

I understand students' health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff and other pertinent LCASD staff.

By signing below you agree you have reviewed this health plan for your child and that the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

PARENT/GUARDIAN SIGNATURE:	**DATE:**

Principal’s Initials: ______________ **Date:** ______________