



VALLEY CHRISTIAN SCHOOL
FAITH • LEARNING • COMMUNITY

Medication Dispense Authorization Form

While your student is at school, they may become ill and require medication. Currently, the office staff dispenses the medications listed below. Please indicate which over-the-counter medications you authorize the office staff to administer to your student.

Office Staff **can** give:

| | | |
|--------------|---------------------|-------------------|
| Tylenol | Ibuprofen | Tums |
| Neosporin | Cough Drops | Bag Balm/Lip Balm |
| Pepto Bismol | Cortisone Cream | Midol |
| Other: | Benadryl Cream/Oral | |

If you would like the office staff to administer the medications listed below to your student, please send the medication with a note and/or prescription if appropriate, and provide the dosage amount, when it should be administered, and written consent for the office staff to dispense.

- Cough syrup
- Mucinex
- Prescription Medications
- Other:

By signing this letter, I, _____, allow my student(s), _____ to be given the above medications when needed. I understand that if my child(ren) is under the age of 12, I will receive a phone call before any medication (except topical creams/balms) is administered.

Parent/Guardian Signature: _____

Date: _____

I **do not allow** my student to be given *any* medications when needed during school. Please understand this means that your student will be refused medication if they ask. If you have any questions or concerns, please contact the school at (509) 924-9131.

Parent/Guardian Signature: _____

Date: _____