



Student Name: _____ Grade: _____
Please Print

Please list any allergies to medications, foods, insects, and/or environmental substances:

Med/Substance	Type of Reaction
_____	_____
_____	_____
_____	_____

Provide any information concerning pertinent medical conditions and or diagnoses:

Please check below any/all over-the counter medications that you consent to be given to your child by ECA staff when deemed necessary. *No aspirin or aspirin containing products will be available in the office.*

Medication	Dosage
Acetaminophen (Tylenol)	_____
Ibuprofen (Motrin)	_____
Benadryl (or generic equivalent)	_____

I do not want any over-the counter medications given to my child: _____
Parent/Guardian

Provide the following information for any prescription medications you wish your child to receive:

Medication	Dosage	Time to be given
_____	_____	_____
_____	_____	_____

I allow ECA to use Neosporin ointment on my child for a small cut or scrape ____ Yes ____ No

I, _____, parent/guardian of _____ do hereby request that the ECA Staff administer the above over-the counter and/or prescription medications to my child when necessary or as indicated. I absolve and release the ECA Staff, administration and the Board from any claim due to any negative reaction by my child when given the medication listed above in the prescribed dosage.

DATE _____ PARENT/GUARDIAN _____

Home phone _____ Work phone _____ Cell phone _____