Revised January 2018

Parental Approval for Medication

I am the parent/guardian of ______________________________. I request and authorize that my child be administered medication in the manner listed below during his/her stay in the Greene County Detention Center.

____

Parent Signature Date/Time

Please initial all that apply

________ In the event that the facility medical personnel prescribe any over the counter medication, my child may receive the over the counter medications checked on the back of this form.

________ My child may also receive the medications listed below: (ALL MEDICATIONS MUST BE IN THE ORIGINAL BOTTLE WITH A CURRENT ORIGINAL LABEL FROM THE PHARMACY)

MEDICATION	DOSAGE	REASON FOR TAKING

If my child is in need of any vaccinations to be enrolled in Springfield Public Schools, I ____________________
Parent signature

☐ Give permission for vaccinations to be given ☐ Decline these services

Please list any of the following information:

Allergies to medications and type of reactions: ☐ None ______________________________

____

Allergies to foods and type of reactions: ☐ None ______________________________

____

Any other know allergies and type of reaction: ☐ None ______________________________

____

Health Issues: ☐ None

Please mark below any that apply and recent problems, or treatments that will help us better care for your child

☐ Asthma:
☐ ADD/ADHD:
☐ Diabetes
☐ STD/Pregnancy

☐ Seizures:
☐ Heart Problems:
☐ Drugs/Alcohol:
☐ Other:

____

____

In the event that an employee or a juvenile of the Juvenile Detention Center is exposed to blood or bodily fluids from the above named juvenile. I hereby give permission for the above named juvenile to be tested for the Human Immunodeficiency Virus (HIV) and for Hepatitis Virus and for the release of such test results as permitted by law.

______________________________ ______________________________

Parent/Legal Guardian Signature Date Staff Signature Date

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Greene County Juvenile Detention Center
Parental Approval for Medication

Please place a check next to the over the counter medications you **approve** for your child to have if needed per complaint or symptoms. The dosage will be the standard dosage as indicated on the medication label.

Pain Medication:

- [ ] Tylenol 325 mg/acetaminophen 1-2 tablets every 4-6 hours
- [ ] Tylenol 500 mg/acetaminophen 1-2 tablets every 6 hours
- [ ] Ibuprofen 200mg 2 tablets every 4-6 hours

Stomach Problems

- [ ] Antacid tablets as directed for indigestion
- [ ] Pepto Bismol/Bismuth Subsalicylate as directed for indigestion, heartburn, diarrhea
- [ ] Kaopectate/Biscodyl as directed for constipation

Allergy Symptoms

- [ ] Claritin/Loratadine 10mg 1 tablet as directed for allergy symptoms
- [ ] Benadryl 25 mg 1 tablet every 6 hours for allergy symptoms
- [ ] Benadryl 50 mg 1 tablet every 6 hours for allergy symptoms

Sore Throat/Cough

- [ ] Throat lozenges as directed for sore throat

Oral/Nasal Symptoms

- [ ] Saline nasal spray as directed for dry or irritated nasal passages

Eyes:

- [ ] Eye Rinse purified water for irritated eyes

Topical creams and ointments:

- [ ] Antifungal cream for fungal issues/athletes feet, ringworm, etc.
- [ ] Triple antibiotic cream for minor cuts/scrapes/ abrasions, etc.
- [ ] Hydrocortisone cream 1% for minor rash or itching, etc
- [ ] Lip balm for chapped lips
- [ ] Acne Cream for acne

Please discuss with the nurse any other medical needs your child may have