

# OVER-THE-COUNTER MEDICATIONS

## Outdoor Lab Summer Camp

### OVER-THE-COUNTER (OTC) MEDICATIONS:

The Outdoor Lab Camp will have available the OTC medications listed below. If you want your child to be able to receive one or more of these medications, please have your physician sign the "Authorization for Medication Release and Indemnification Form" included in this packet, indicating that the items listed below may be given **on an as-needed basis**, and then attach this list to the signed form. You may cross out any medications you do NOT want your child to receive.

- A+D Ointment (topical, for chafing/heat rash)
- Aloe Vera gel (topical, for sunburn relief)
- \*\*Acetaminophen (Tylenol) (tablets or chewable, for minor pain relief)
- Benzocaine (Orajel). Topical for toothache pain.
- \*\*Bismuth Subsalicylate (Pepto-Bismol) liquid (for upset stomach/diarrhea)
- Calamine/Caladryl lotion (topical, for itch relief)
- \*\*Diphenhydramine HCl (Benadryl) (chewable or liquid, as antihistamine for allergies)
- \*\*Ibuprofen (Advil/Motrin) (chewable or liquid, for minor pain and inflammation)
- Lidocaine spray (for minor burn relief)
- Sting-Eze – Benzocaine (topical, for insect sting relief)

\*\* Whenever one of the oral (\*) OTC medications is administered to your child, you will be notified beforehand or at the earliest practical time afterward. The oral medications will be given in dosages appropriate for weight, as per the manufacturer's recommendation.

I acknowledge receipt of this information concerning administration of over-the-counter medications.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Camper's Name \_\_\_\_\_ Camper's Weight \_\_\_\_\_

**Any known medication allergies?** List them. \_\_\_\_\_

# Over-the-Counter Medications

## AUTHORIZATION FOR MEDICATION RELEASE AND INDEMNIFICATION AGREEMENT

**PARENT or GUARDIAN (Must complete TOP SECTION for every medication)**

I hereby authorize Arlington Department of Human Services and Arlington Public Schools personnel to give the medication as directed by this authorization. I agree to release, indemnify, and hold harmless Arlington Public Schools and Arlington County, and any of its officers, staff members, or agents from lawsuit, claim, expense, demand, or action, etc., against them arising out of or in connection with assisting this student with the use of medication. I have read the "Procedures for Administering Medication in Schools" on the reverse side and assume the responsibilities as set forth.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_

Teacher Name: \_\_\_\_\_ Attends Extended Day: Yes \_\_\_\_\_ No \_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**To Be Completed by the Licensed Prescriber:** The Arlington Department of Human Services and the School Health Bureau discourage medications be given to students in school during the School/Extended Day. Please prescribe for before or after school, if at all possible.

Name of Medication: See attached list Dosage: Dose as per manufacturer's instructions

Time To Be Given At School: \_\_\_\_\_ A.M. and/or \_\_\_\_\_ P.M. and/or Before/After \_\_\_\_\_ Activity

Diagnosis: \_\_\_\_\_ Date To Begin: \_\_\_\_\_ Date To End: \_\_\_\_\_

If the student is taking more than one medication at school, list the sequence in which medications are to be taken and the length of interval between each medication.

If a medication is to be given on an "as needed" basis, specify the symptoms or conditions when the medication is to be given and the time interval for repeating the dose/medication.

\_\_\_\_\_  
PHYSICIAN'S NAME (PRINT OR TYPE)

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Date \_\_\_\_\_

**MIDDLE AND HIGH SCHOOL STUDENTS WHO CARRY INHALERS:** This student is both capable and responsible to self-administer the above inhaler(s). This student may carry his/her inhaler.

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
PARENT'S SIGNATURE

\_\_\_\_\_  
STUDENT'S SIGNATURE

Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

**FOR STAFF ONLY:** Signing here indicates that the medication review has been completed.

\_\_\_\_\_  
SHA Signature and Date

\_\_\_\_\_  
Name of PHM Contacted by Phone and Date

\_\_\_\_\_  
PHN Signature and Date

PROCEDURES FOR ADMINISTERING MEDICATION IN THE SCHOOLS  
(Rev 08/99)

The goal of the School Health Services in the administration of medications to your child is SAFETY – the right medicine, to the right child, in the right amount, at the right time. Your help is needed to achieve this goal!

Please arrange to give all doses of medications at home whenever possible. However, if your child needs medication at school follow these 11 steps:

1. A separate Authorization form (reverse) completed by the parent/guardian and licensed prescriber is required for each medication. This is valid for no longer than one-school year.
2. Faxed copies of the Authorization are accepted.
3. Whenever there is a change in medication dose or time or administration new Authorization form and new labeled medication container are required.
4. When the medication need to be taken at home AND at school, ask the pharmacist for two (2) labeled containers – one for home and one for school.
5. If your child has special requirements for taking the medication, (e.g., with applesauce, medicine needs to be broken in half, and/or elementary students wants to carry his/her inhaler) please discuss this with the school clinic staff.
6. **Medication Containers:**
  - A. All prescription medications must have a pharmacy label with the following information:
    - Time to be given – specify hour or activity (12 noon, after lunch, before P.E.) NOT “ given as indicated”
    - Child’s name
    - Name of medication
    - Physician’s name
    - Dose/amount to be given
  - B. All OTC (over-the-counter) medications and physician samples. Parents **MUST**:
    - Submit an authorization form completed by Parent/Guardian and Licensed Prescriber
    - Send the medication to the clinic in the original container whenever possible or otherwise in a container labeled with the child’s name, medications and dose.
7. Medications will be given no more than 30 minutes before or after the prescribed time.
8. Middle and High School students with asthma may carry and self-administer inhaler with a completed Authorization form on file in the clinic. The student and parent/guardian must agree that:
  - The student will not share the inhaler with any other student.
  - The student will carry or keep the inhaler in a secure, concealed place.
  - The student’s name must be written on the inhaler.
9. Parents/guardians are advised to hand-deliver medications with Authorization forms directly to the elementary school clinic. At your discretion, middle and high school students may deliver their medications and Authorization forms to the school clinic.
10. Field Trips or other off-site school activities (e.g. Outdoor Lab) – Please discuss arrangements for medications with the school clinic staff.
11. Unused medications should be picked-up within one (1) week of expiration date of order. After that time it will be destroyed by the PHN.