

**Shannon Forest Christian School**  
**Windy Gap Medication Sheet for 2010-2011**

Student's name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**List all allergies:** \_\_\_\_\_

\_\_\_\_\_

**While at Windy Gap, miscellaneous over the counter medications will be available. Please check *any medications* you will allow your child to be given if needed. Indicate the appropriate dosage, frequency, and indication.**

\_\_\_\_\_ Ibuprofen – dosage: \_\_\_\_\_ frequency \_\_\_\_\_ indication \_\_\_\_\_

\_\_\_\_\_ Tylenol – dosage: \_\_\_\_\_ frequency \_\_\_\_\_ indication \_\_\_\_\_

\_\_\_\_\_ Benadryl - dosage: \_\_\_\_\_ frequency \_\_\_\_\_ indication \_\_\_\_\_

\_\_\_\_\_ Hydrocortisone cream: dosage \_\_\_\_\_ frequency \_\_\_\_\_ indication \_\_\_\_\_

\_\_\_\_\_ Rolaids – dosage: \_\_\_\_\_ frequency \_\_\_\_\_ indication \_\_\_\_\_

\_\_\_\_\_ Sudafed– dosage: \_\_\_\_\_ frequency \_\_\_\_\_ indication \_\_\_\_\_

\_\_\_\_\_ Cough Drops – dosage: \_\_\_\_\_ frequency \_\_\_\_\_ indication \_\_\_\_\_

**Any routine medications your child may need will have to be provided by you. *All medications must be in the original container, whether over the counter drugs or prescription. Only send what your child will use during the 3 days at Windy Gap.* Unused medication will be discarded if not picked-up by parent. Please list each medication with the dosage, frequency, and indication. Parents must bring in the medications along with this form to school nurse no later than Monday, October 4.**

**If your child uses an inhaler on occasion, record information below and send this form to the school nurse. Send inhaler with your student to Windy Gap.**

1. Name of medication: \_\_\_\_\_ dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_ indication: \_\_\_\_\_

2. Name of medication: \_\_\_\_\_ dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_ indication: \_\_\_\_\_

3. Name of medication: \_\_\_\_\_ dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_ indication: \_\_\_\_\_

4. Name of medication: \_\_\_\_\_ dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_ indication: \_\_\_\_\_

Print Name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_