**PERMISSION FOR DIAPER OINTMENT**

**Non–toilet trained students ONLY**

Roanoke City Student Health **A separate form is required for each medication**

Student Name: Date of Birth:

School: Grade: School Year:

Teacher/Team/Hall: Student ID#:

Medication:

**A & D ointment**

For the treatment of:

**Diaper rash**

Dosage:

**Thin layer to affected area areaarea**

Route: **topical**

Administration Time:

**PRN** at diaper change

**Duration: Order will be valid for the above named school year including summer school unless otherwise specified.**

Possible side effects/special instructions or precautions:

I certify that, in my opinion, it is medically necessary for the medication described above to be administered during school hours and that this medication may safely be administered by appropriately trained, designated school personnel.

Printed Name of Prescriber**:**

**Dr. Amy Kryder per Medication Protocol**

I hereby request that my child (i.e., the student named above) be given the above medication while in school and also when away from school for official activities. I understand that the medication may be given by trained non-medical school personnel, and I give permission for said trained non-medical personnel to administer the above listed medication. I understand that medication administration will not begin until the completed

parental permission forms are on file with the school, and school personnel have received instruction concerning the administration of the medication listed above. I understand and agree the School Board, and their officers, agents, and employees are not responsible for any effects of the medication administered.

I understand that I must promptly provide the school with written notification of any changes in my child’s condition, medication(s), or dosage.

I hereby give my permission for (Student Name) to use the above medication at school as ordered. I understand that this permission form is valid for only one school year and that a new form must be completed at the beginning of each school year.

*Date Signature of Parent or Guardian* ***{*required for prescription and non-prescription medication}**

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*Parent/Guardian Address 1st Phone Number to Call 2nd Phone Number to Call*

**Revised 06/2017**