



2024-2025 MEDICAL INFORMATION CARD

Parent/Guardian Name: _____

- I DO NOT authorize Faith Christian School to administer over-the-counter medication to my child.
- I give permission for any employee of Faith Christian School to give my child the following over-the-counter medicines:
(indicate dosage or check age appropriate dosing):

1. Child's Name, Age, and Grade: _____

Dosage

- Acetaminophen (Tylenol) _____
- Ibuprofen (Advil) _____
- Antacid (Tums) _____
- Antihistamine (Benadryl) _____
- Neosporin ointment _____
- Hydrocortisone cream _____
- Age appropriate dosing**

Known Allergies OR Medication Intolerances: _____

Chronic Illnesses or Medical Conditions: _____

Scheduled medications (prescription or over-the-counter), include indication, dosage and frequency:

2. Child's Name, Age, and Grade: _____

Dosage

- Acetaminophen (Tylenol) _____
- Ibuprofen (Advil) _____
- Antacid (Tums) _____
- Antihistamine (Benadryl) _____
- Neosporin ointment _____
- Hydrocortisone cream _____
- Age appropriate dosing**

Known Allergies OR Medication Intolerances: _____

Chronic Illnesses or Medical Conditions: _____

Scheduled medications (prescription or over-the-counter), include indication, dosage and frequency:

3. Child's Name, Age, and Grade: _____

- | | Dosage |
|--|--------|
| <input type="checkbox"/> Acetaminophen (Tylenol) | _____ |
| <input type="checkbox"/> Ibuprofen (Advil) | _____ |
| <input type="checkbox"/> Antacid (Tums) | _____ |
| <input type="checkbox"/> Antihistamine (Benadryl) | _____ |
| <input type="checkbox"/> Neosporin ointment | _____ |
| <input type="checkbox"/> Hydrocortisone cream | |
| <input type="checkbox"/> Age appropriate dosing | |

Known Allergies OR Medication Intolerances: _____

Chronic Illnesses or Medical Conditions: _____

Scheduled medications (prescription or over-the-counter), include indication, dosage and frequency:

4. Child's Name, Age, and Grade: _____

- | | Dosage |
|--|--------|
| <input type="checkbox"/> Acetaminophen (Tylenol) | _____ |
| <input type="checkbox"/> Ibuprofen (Advil) | _____ |
| <input type="checkbox"/> Antacid (Tums) | _____ |
| <input type="checkbox"/> Antihistamine (Benadryl) | _____ |
| <input type="checkbox"/> Neosporin ointment | _____ |
| <input type="checkbox"/> Hydrocortisone cream | |
| <input type="checkbox"/> Age appropriate dosing | |

Known Allergies OR Medication Intolerances: _____

Chronic Illnesses or Medical Conditions: _____

Scheduled medications (prescription or over-the-counter), include indication, dosage and frequency:
