Greene County Juvenile Detention Center
Parental Approval for Medication

I am the Parent/Guardian of_____. I request and authorize that my child, (previously listed) be administered medication in the following manner during his/her current stay in Greene County Detention: (please initial all that apply)

_____ ☐ In the event that the facility medical personnel prescribes any over the counter medication. My Child may receive the over the counter medications checked on the back of this form.

Phone permission_____/_____/_____
Name of Parent/Guardian Name of Staff Making Call Date /Time

_____ ☐ My Child may also receive the medications listed below: **(ALL MEDICATIONS MUST BE IN THE ORIGINAL BOTTLE WITH ORIGINAL LABEL FROM THE PHARMACY OR WITH A NEW WRITTEN PRESCRIPTION FROM THE DOCTOR)**

MEDICATION	DOSAGE	REASON FOR TAKING

Phone permission_____/_____/_____
Name of Parent/Guardian Name of Staff Making Call Date /Time

Allergies to Medications and type of reaction: ☐ None _____

Allergies to Food and type of reaction: ☐ None _____

Other Allergies and type of reaction: ☐ None _____

Health Problems: ☐ None (Please list recent problems with that disease, treatments, anything that will help us better care for your child)

☐ Asthma_____ ☐ Seizures_____

☐ ADD/ADHD_____ ☐ Heart Problems _____

☐ Diabetes_____ ☐ Drugs/Alcohol_____

☐ STD/Pregnancy_____ ☐ Other _____

In the event that an employee or a juvenile of the Juvenile Detention Center is exposed to blood or body 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.

_____ _____
Staff Signature Parent/Legal Guardian Signature

_____ _____
Date Date

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Please choose the over the counter medications you prefer your child to have. The dosage will be the standard dosage unless specified.

Pain Medication

Choose one ☐ Tylenol 500 mg 1-2 tablets every 4-6 hours as needed for pain

Or

☐ Ibuprofen 200 mg 2 tablets every 4-6 hours as needed for pain

Stomach Problems

May Choose multiple ☐ Tums as directed for indigestion or heartburn as needed

☐ PeptoBismol as directed for indigestion, heartburn, diarrhea as needed

☐ Kaopectate as directed for constipation as needed

Allergies

Choose one ☐ Benadryl 25 mg 1 tablet every 6 hours allergies, itching as needed

Or

☐ Claritin 10 mg 1 tablet daily for allergies as needed

Sore Throat

Choose one ☐ Chloraceptic Throat Lozenges as directed sore throats as needed

Cough

Choose one ☐ Cough Drops as directed as needed

Topical Creams and Ointments

May Choose Multiple ☐ Antifungal Cream for athletes feet, ring worm, etc as needed

☐ Triple Antibiotic Cream for minor cuts and scrapes as needed

☐ Hydrocortisone Cream 1% for minor rash, itching as needed

☐ Lip Balm for chapped lips as needed

☐ Acne Cream as needed

If your child is in need of other medications please discuss this with the nurse. If the nurse is not in the office leave a message and the nurse will call you.

Please list any other information which may be helpful in caring for your child. If you would like to speak with the nurse again tell the staff and they will have the nurse call.

Comments: _____