MEDICATION ADMINISTRATION CONSENT

NAME________________________________AGE______DOB_______YOG_______

Medication allergies:

List any medications your child receives regularly:

I give permission for my child _____________________________to receive any medication I have indicated below as deemed necessary by the school nurse. I understand the generic equivalent may be used in place of more expensive name brands
.

PLEASE CHECK ANY OVER THE COUNTER MEDICATIONS YOU WISH TO BE MADE AVAILABLE TO YOUR CHILD UNDER NURSING DISCRETION. DOSAGE DETERMINED BY AGE AND/OR WEIGHT.

For headache/fever/muscle aches/ menstrual cramps:

( ) Acetaminophen (like Tylenol)
( ) Ibuprofen (like Advil, Motrin)- best for menstrual cramps, muscle/bone pain

For mild allergic reactions (such as hives):

( ) Benadryl (Diphenhydramine)

For mild cold symptoms:

( ) Sudafed PE (Phenylephrine) ( ) Throat lozenges/cough drops ( ) Robitussin DM

For mild stomach discomfort:

( ) Antacid

For mild skin irritation (poison ivy, insect bites, minor rashes):

( ) Calamine lotion ( ) Hydrocortisone cream 1%

( ) I do not want any medication to be given to my child in school.

I understand that the above medications I have checked will be administered by the school nurse in accordance with established protocols endorsed by the medical consultant physician.
Parent/Guardian Signature ______________________________Date _______________

Revised 6/1/17