The Catholic High School of Baltimore

MEDICATION ADMINISTRATION CONSENT

NAME_____AGE_____DOB_____YOG_____

Medication allergies:

List any medications your child receives regularly:

I Authorize the school nurse, or designate to administer the following medications at their discretion. (Please check all that apply):

For headache/fever/muscle aches/ menstrual cramps:

( ) Acetaminophen (like Tylenol) 325mg - 2 tabs every 4-6 hours as needed

( ) Ibuprofen (like Advil, Motrin) 200mg – 2 tabs every 4-6 hours as needed

For mild allergic reactions (such as hives):

( ) Benadryl (Diphenhydramine) 25mg – 50mg (parents will be notified)

For mild cold symptoms:

( ) Sudafed PE (Phenylephrine10mg) every 4 hours as needed

( ) Throat lozenges/cough drops 1 every 2 hours as needed.

( ) Robitussin DM 10ml every 4-6 hours as needed

For mild stomach discomfort:

( ) Antacid as directed

For mild skin irritation Topical Medication:

( ) Hydrocortisone cream 1% or ( ) Calamine lotion for minor skin irritations like poison ivy, insect bites, minor rashes:

( ) Antibiotic Ointment (like Bacitracin, Neosporin)- for minor cuts/abrasions

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

I give permission for my child _____ to receive any medication I have indicated above as deemed necessary by the School Nurse. I understand that generic equivalent medications may be used.

Parent/Guardian Signature _____Date _____

Physician Signature: _____Date: _____

REQUIRED: Apply Physician's Address Stamp here: