SCHOOL NURSE
Medication Consent Form
2021-2022

Contact information: **Preferred Phone**: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Email: _____

Last Name: _____

List Students in school: _____Grade_____ No Allergies ☐ Allergies: _____
_____Grade_____ No Allergies ☐ Allergies: _____
_____Grade_____ No Allergies ☐ Allergies: _____
_____Grade_____ No Allergies ☐ Allergies: _____
_____Grade_____ No Allergies ☐ Allergies: _____

The above listed students have my permission to be administered the following medications during the current school year.

_____

(Parent Signature)

OVER THE COUNTER MEDICATION

***I give permission to give my child(ren) the following over-the-counter medications (check all appropriate*):

☐ Neosporin / Polysporin
☐ Hydrocortisone/Benadryl cream
☐ Benadryl (oral)
☐ Acetaminophen (ex: Tylenol)
☐ Ibuprofen (ex: Advil/Motrin)
☐ Tums tablets
☐ Cough drops

☐ ***I wish to be notified before giving my child(ren) any medication***

*** All medication will be dosed by the child's weight, or recommendation on the bottle unless otherwise specified by physician ***

PRESCRIPTION MEDICATION to be GIVEN AT SCHOOL

****All prescription medication that needs to be given while at school MUST be in the pharmacy bottle labeled with the name of child, medication, dosage and physician's name; the label will serve as the physician's signature. The school must be notified in writing if medication is discontinued.*

☐ Inhaler: Medication/child_____ (ex: Albuterol)
Dose to be given: _____(ex: # of puffs)
Time of day to be given: _____
Reason for Rx:_____
Possible side effects: _____

☐ Medication/child:_____
Dose to be given: _____
Time to be given: _____
Reason for Rx: _____
Possible side effects:_____