MEDICATION ADMINISTRATION CONSENT FORM

Name _____ Age_____ DOB_____ YOG_____

Medication Allergies _____

I authorize the school or designate to administer the following medications at their discretion.
Please check all that apply.

For headache/fever/muscle aches/menstrual cramps:

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

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

For mild allergic reactions (hives, etc):

( ) Diphenhydramine (Benadryl) 25-50 mg one dose (Parent will be notified)

For mild cold symptoms:

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

( ) Throat lozenges / Cough drops - 1 every 1-2 hours as needed

( ) Nasal Decongestant (Phenylephrine HCl) 10 mg - 1 tab every 4 hours as needed

For mild stomach discomfort:

( ) Antacid (Tums) as directed

For mild skin irritations (Topical Medication - poison ivy, insect bites, minor rashes):

( ) Hydrocortisone cream 1% and/or ( ) Calamine lotion

( ) Triple Antibiotic Ointment for minor cuts/abrasions

( ) I DO NOT WANT ANY MEDICATION TO BE ADMINISTERED TO MY DAUGHTER IN SCHOOL

I give permission for my daughter to receive any medication that I have indicated above as deemed necessary by the school nurse. I understand that generic equivalent medication may be used.

Parent/Guardian Signature _____ Date_____

Physician Signature_____ Date_____

REQUIRED: Apply Physician's Address Stamp below: