Medication Consent Form
To be completed by Parent or Guardian of Student

Student’s Name_________________________________ Date_____________________
Homeroom __________________________________ Room # _________________

Please read. Check (✔) all that apply and initial that section. Please sign the bottom that you have read the entire page.

There are 3 medications that we have available for students. They are acetaminophen, ibuprofen, and Benadryl. At any time during the school year that the student requires prescription medication (antibiotics, cough medicine, etc.) a doctor’s note is required and must be presented to the school’s health office. If there are other medications that your daughter takes for cramps/headaches/migraines, please list below and provide the medication with the student’s name on it. If they cannot swallow medicine, send in the liquid form with the dosage.

☐ This student may not be given any medication.

Please initial: __________   (If this is your choice, then proceed to bottom of page and sign)
_________________________________________________________________________________

I give the school nurse / school administrator / office personnel permission to distribute the following medications for headaches /menstrual cramps/fever/muscle aches:

☐ Acetaminophen (generic Tylenol) (2 tablets) – 325mg each tablet
☐ Ibuprofen (generic Advil/Motrin) (2 tablets) – 200mg each tablet
☐ Benadryl (1) 25mg tablet
☐ Other – Please indicate below and provide medication:

Medication: ___________________________ Dosage: ___________ Reason: ______________________
Medication: ___________________________ Dosage: ___________ Reason: ______________________

Please initial: __________
_______________________________________________________________________________

This student takes the following medications regularly and/or needs to carry them in case of an emergency and has permission to carry them with her and take them in school:

☐ Asthma Pump
☐ EPI Pen – Please state allergy requiring Epi-Pen: __________________________
☐ Insulin Pen

Please initial: __________

PLEASE NOTE!!
These medications (asthma pump, epi and insulin pens) should be carried by the student. A spare may be given to the Health Office should an emergency arise. Properly label the medication with the students’ name. It is important to make note of the expiration date and provide a new one should it expire during the school year.

☐ I give permission for the “school official” to administer these medications should an emergency arise and I agree to provide a new one if/when it expires.

Please initial: __________

I have read the above and understand and have initialed where necessary.
Parent’s/Guardian’s Signature __________________________________

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