Sheppard Pratt School

Consent for Administration of Approved Discretionary Medications

Student Name: _____ **Date of Birth_____**

List ALL Current Prescription Medications & Over-the-Counter Medications your child takes daily, including psychiatric and other medications.

	Medication:	Dose/Times	Reason/Diagnosis
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Does your child use a RESCUE INHALER ☐ **Yes** ☐ **No**

Does your child use an EPI PEN ☐ **Yes** ☐ **No**

Primary Care Physician_____ **Phone Number_____**

Prescribing Psychiatrist _____Phone Number_____

No Known Drug Allergies ☐

ALLERGIES/SENSITIVITIES

Medication	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies

Foods/Other	**Reaction**
_____	_____
_____	_____
Seasonal _____	Environment _____
Insects/Animals_____	_____

I give Permission for my child_____ to receive the medication(s) indicated below when deemed **necessary by the School Nurse and/or approved by Dr. Larson.**

Please check the medications you would like to have given to your child, if needed:

☐ Acetaminophen (i.e. Tylenol) or Ibuprofen for pain and/or fever
☐ Cold/Allergy medication
☐ Diphenhydramine (i.e. Benadryl) mild allergic reactions

The Medications ABOVE cannot be given with some medications that are prescribed. The nurse will need to contact you to obtain an updated list of all medications your child is currently taking before we will approve the administration of any of the ABOVE medications.

Please check the medications you would like given to your child, if needed:
☐ Hydrocortisone cream 1-2% for itching/rash/poison ivy
☐ Antibiotic First Aide Cream for cuts/scratches/abrasions
☐ Benadryl (topical gel) for itching for insect bites
☐ Calamine lotion for itching
☐ Bug spray/Sun block lotion
☐ Throat lozenges for cough or sore throat
☐ Antacid tablets (i.e. TUMS) for heartburn or upset stomach
☐ Cold and allergy medications (Dilatab for Congestion aid)
☐ Eyewash

I understand that the medications I have checked will be administered by the School Nurse in accordance with established protocols developed by our physician.

☐ **I do not want any medication given to my child in school.**

Signature of parent/guardian _____ Date_____

Home phone _____ Work/Cell/Emergency Phone_____

Kathleen King _____ Date_____

Justine J. Larson, MD _____ Date_____

AUTHORIZATION AND PERSMISSION TO ADMINISTER MEDICATION

Name of Student: _____ (please print)

I request the above-named student be given medication at school and school activities by qualified staff according to the prescription instructions. A record of medication(s) given will be maintained in my child's chart. The student has experienced no previous side effects from the medication(s). I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment. Further, the medication will be in the original labeled container with the student's name, name of medication, along with directions for use and dosage information.

Parent/Guardian: _____

Date: _____