Sheppard Pratt
School

**Consent for Administration of Discretionary Medications/Sunscreen Form**

School Year: _____
Student Name: _____ DOB: _____

**Allergies:**

( ) No Known Drug Allergies

( ) Please list Drug Allergies identified on Medical Form:

_____ _____ _____ _____

( ) I do ***not*** want my child to receive any medications in school.

( ) I do **give** consent for my child to receive the medications indicated below.

**Medications:** Please check the following medications you authorize to be administered to your child when the school nurse's assessment indicates a need:

( ) Acetaminophen/Tylenol for pain for pain and/or fever ≥ 100F orally

( ) Ibuprofen/Motrin for pain and/fever ≥ 100F orally

( ) Diphenhydramine/Benadryl for mild allergic reactions

( ) Throat Lozenges/Cough Drops for sore throat, cough

( ) Antibiotic creams/ointments (i.e. Bacitracin/Neosporin) for minor cuts, scratches, abrasions

( ) Hydrocortisone Cream 1-2% for rashes, itching, inflammation

( ) Claritin for allergy symptoms

( ) Tums/Maalox for heartburn, upset stomach

( ) Other Topicals (i.e. Benadryl ointment/Calamine lotion) for insect bites/itch relief

*I understand that the medications I have indicated will be administered by the school nurse and under the orders of the assigned school physician.

**Sunscreen:** Sheppard Pratt Schools practice Sun Safety during outdoor activities.

I give consent for my child to wear Sunscreen. ( ) No ( ) Yes

**If yes, parent is responsible for supplying their child's Sunscreen with a SPF (sun factor protection) 15 (or greater) to the school. School staff will assist students with application if/as needed.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of School Nurse Date

Sheppard Pratt School

## Authorization for Medication Form

School Year: _____
Name of Student: _____ DOB: _____

The following procedures regarding administration of medication apply to all students while attending the Sheppard Pratt Schools:

1. Students may be evaluated for medication needs by the school's assigned consulting psychiatrist. If a recommendation for a medical evaluation is warranted, parents will be notified. Sheppard Pratt Schools will not, and cannot, evaluate or medicate students without parental permission.
2. If prescription medications are to be administered during the school day, it is required that a ***Maryland State School Medication Administration Authorization Form*** be completed for ***each*** prescribed medication. This form will require signatures both from parent and prescriber.
3. Sheppard Pratt Schools will ***not*** supply the student's prescription medications. It is necessary for the school to be provided with the medication(s) in a properly labeled pharmacy bottle which designates the following: student's name, physician's name, name of medication, dosage, date of prescription and directions for use. The school nurse will request a new pharmacy labeled bottle if the date on the prescription bottle is greater than 3 months old.
4. Over-the-counter medications may be administered as indicated on the ***Consent for Administration of Discretionary Medications/Sunscreen Form*** with signed parental consent.

I request that the above-named student be given medication by designated school personnel according to the physician's order during school and school activities. If medication was prescribed by a non-Sheppard Pratt prescriber, I confirm that the community provider has reviewed the risks, benefits, side effects and that my child has not experienced any side effects from the medication(s).

I understand that according to school policy, students may not carry/possess any medication on their person (prescribed or over-the-counter) in the school or on the school bus.

I agree to provide the school with a 30-day supply of medication(s). I understand that if I have difficulty delivering the medication(s) to school, I must discuss alternative arrangements with my child's treatment team.

I authorize the school nurse and/or designee to administer my child medication(s). I will not hold liable any school personnel who is designated to administer my child's medication.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of School Nurse Date