MEDICATION CONSENT FORM
(Consent is for 12 months only)

Student:____ **DOB**:____________

Known Medical Conditions (circle): Drug Allergy Food Allergy Asthma ADD/ADHD Urinary Incontinence/Constipation Other
Explain:____

Does your child receive any specialized care or see a specialist?
Explain:____

____

PRESCRIBED MEDICATIONS to be administered at school:

Medication:________________________________Dose:_______________ Time:____________

Diagnosis/Reason for Medication:____

____

Medication:________________________________Dose:_______________ Time:____________

Diagnosis/Reason for Medication:____

____

Medication:________________________________Dose:_______________ Time:____________

Diagnosis/Reason for Medication:____

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Special Instructions/Comments: ____

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OVER THE COUNTER MEDICATIONS to be administered at school as needed *(circle YES/NO)*

Tylenol (Acetaminophen)-dosed by age/wt—————————— YES NO

Motrin (Ibuprofen)-dosed by age/wt———————————— YES NO

Benadryl (Diphenhydramine)-dosed by age/wt-————————— YES NO

Zyrtec (Cetirizine 10mg)-for seasonal allergies—————————— YES NO

Antibiotic Ointment (Bacitracin)-abrasions-—————————— YES NO

Diphenhydramine Cream-anti-itch cream—————————— YES NO

Hydrocortisone Cream-anti-inflammatory cream————————— YES NO

Please Note: Prescribed medications cannot be dispensed from unlabeled containers. They must be sent in a labeled prescription container from the pharmacy.

Students are not allowed to carry medications (prescriptive or over-the-counter) with them. All medications are to be kept with the school nurse in the health room. Students with proper authorization may be allowed to carry and self-administer asthma or other medications for life threatening conditions.

Parent/Guardian Permission: I hereby give my permission for designated school personnel to administer the medication listed above as directed by the prescribing health care professional or the over-the-counter medication label age-dosing guidelines. I accept responsibility for immediately notifying the staff of any change in these instructions. Further, I indemnify and hold harmless this school, parish, the Kansas City-St. Joseph Diocese and its employees or agents against any claim from the use of these medications.

______________________________ ________________

Parent/Guardian Signature Date

(use backside of form if needed)