



HARFORD COUNTY PUBLIC SCHOOLS HEALTH SERVICES

CONSENT FOR ADMINISTRATION OF APPROVED DISCRETIONARY MEDICATIONS AND HEALTH CONTACT INFORMATION 2011-2012

Student Name: _____ M / F DOB: _____ Gr: _____

Student Weight: _____ Last _____ First _____ Homeroom Teacher: _____ Bus #: _____ Walker _____

Home Address: _____ Street _____ Town _____ Zip Code _____ Home Phone: _____

Medication Allergies/Sensitivities: _____

List ALL Medications your student takes on a regular basis: _____

Reason: _____

Physician: _____ Phone: _____ Dentist: _____ Phone: _____

MEDICAL/HEALTH PROBLEMS: Check all that apply

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> **Severe Allergy | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Shunt/Hydrocephalus | <input type="checkbox"/> Loss of Vision/Blind |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Kidney/Urinary | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Insect _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Neurological Impairment |
| <input type="checkbox"/> Medication _____ | <input type="checkbox"/> GI Conditions | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Glasses _____ Contacts |
| <input type="checkbox"/> Asthma _____ Rescue Inhaler | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Migraines | <input type="checkbox"/> IEP _____ 504 plan |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cardiac Conditions | <input type="checkbox"/> Orthopedic Concerns | <input type="checkbox"/> Other _____ |

If yes, explain: _____

Long Term Medication: _____ Reason: _____

** If Severe Allergy (please check): Epi Pen _____ Benadryl _____ No Medication _____ Other Medication (severe allergy only) _____

MEDICATION ADMINISTRATION:

I give permission for my student to receive any medication listed below on this form as deemed by the Registered Nurse/Licensed Practical Nurse. I understand that a generic equivalent may be used.

I would like the following medication(s) made available to my student. (Please check)

For Upset Stomach

Chewable Antacid Tablets (Like Tums)

For Mild Allergic Reactions

Diphenhydramine (Like Benadryl)

For Coughs / Sore Throat

Cough Drops (for students age 5 or older with no increased risk of choking)

For Headache/Fever/Burns/Earache/Sore Throat

Acetaminophen (like Tylenol)

For Menstrual Cramps or Muscle Aches/Pain

Ibuprofen (like Advil –for students ages 12 & older)

I do NOT want any medication given to my student in school.

I understand that the above medications I have checked will be administered by the Registered Nurse/Licensed Practical Nurse in accordance with established protocols developed by the Deputy Health Officer, Harford County Health Department and the Nurse Coordinator for Harford County Public Schools.

PARENT/GUARDIAN INFORMATION:

Mother: _____ Home Phone _____ Cell # _____ Work # _____

Father: _____ Home Phone _____ Cell # _____ Work # _____

If parent/guardian cannot be reached only listed persons will be contacted and permitted to pick up student

Name: _____ Relationship _____ Phone _____ Phone _____

Name: _____ Relationship _____ Phone _____ Phone _____

All information may be shared with staff/transportation on a need to know basis unless otherwise notified.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____