HCPS

HARFORD COUNTY PUBLIC SCHOOLS HEALTH SERVICES

DISCRETIONARY MEDICATION FORM 2018-2019

Student Name: _____ DOB: _____ M / F: ____ Gr: _____
Last First MI

Student Weight: _____ Homeroom Teacher: _____ Bus #_____ Walker: ____ Car: ____ Drives: _____

Address: _____ Home Phone: _____
Street Town Zip Code

Medication Allergies/Sensitivities: _____

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

Reason for Medication(s): _____

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

MEDICAL/HEALTH PROBLEMS: Check all that apply.

___Severe Allergy**
Food _____
Insect _____
Medication _____
___Asthma __ Rescue Inhaler
___ADHD

___Bleeding Disorder
___Cancer
___Cardiac Conditions
___Diabetes
___Genetic Disorder
___GI Conditions

___Glasses ___Contacts
___Hearing Impairment
___IEP ___504 plan
___Kidney/Urinary
___Loss of Vision ___Blind
___Mental Health

___Migraines
___Neurological Impairment
___Orthopedic Concerns
___Seizure Disorder
___Shunt/Hydrocephalus
___Other _____

If yes, explain: _____

** IF Severe Allergy Noted Above – Student Uses: EpiPen® _____ 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)

My Child May Self-Carry Cough Drops from Home
☐ (For students >5 y/o. There will be a very limited supply of cough drops in health suite.)

For Mild Allergic Reactions
☐ Diphenhydramine (Like Benadryl)

For Headache/Fever/Burns/Earache/Sore Throat
☐ Acetaminophen (like Tylenol)

For Musculoskeletal Injury/ Menstrual Cramps/Headache
☐ 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 Supervisor of Health Services for Harford County Public Schools.

PARENT/GUARDIAN INFORMATION:

Parent/Guardian #1: _____ **(H) Ph:** _____ **(C) Ph:** _____ **(W) Ph:** _____

Parent/Guardian #2: _____ **(H) Ph:** _____ **(C) Ph:** _____ **(W) Ph:** _____

Parent/Guardian email: _____

IF PARENT/GUARDIAN CANNOT BE REACHED ONLY LISTED PERSONS WILL BE CONTACTED AND PERMITTED TO PICK UP STUDENT

Name: _____ **Relationship:** _____ **Ph:** _____ **Ph:** _____

Name: _____ **Relationship:** _____ **Ph:** _____ **Ph:** _____

***ALL INFORMATION MAY BE SHARED WITH STAFF AND/OR TRANSPORTATION ON A NEED-TO-KNOW BASIS UNLESS OTHERWISE NOTIFIED.**

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____