CONSENT FOR ADMINISTRATION OF APPROVED
DISCRETIONARY MEDICATIONS 2023-2024

Dear Parent/Guardian:

On the reverse side of this letter is a consent form for the administration of certain nonprescription/over-the-counter medications which will be available, at no charge, for all students. This service is available to alleviate your student’s minor discomforts and to avoid early dismissals from school. These medications are approved by the Harford County Health Department and the Supervisor of Health Services for Harford County Public Schools. This service helps our students improve attendance and enhance academic performance. You may signify your permission to have your student self-carry cough drops from home by checking the appropriate box.

Your consent must be obtained before any medication is given to your student. Only the Registered Nurse/Licensed Practical Nurse may administer these medications in accordance with established protocols. The consent form lists the medications which may be available. Please complete the consent form and return it to the school nurse. The consent is in effect for this school year only and will need to be renewed at the beginning of each school year.

Approved discretionary medications are intended for occasional use only. Discretionary medication will administered at the discretion of the school nurse. If your student requires any prescription or nonprescription medication on a regular basis, you must obtain a written order from your health care provider and supply the medications.

If you have any questions or would like further information, please contact your school nurse.

Sincerely,

Jamie Sibel, MD, MPH
Medical Deputy Health Officer
Harford County Health Department

Mary Nasuta, RN, MS, NCSN
Supervisor of Health Services
Harford County Public Schools

Office Use Only

Rev. 7/2023
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**  ___Bleeding Disorder  ___Glasses  ___Contacts  ___Migraines

Food  ___Cancer  ___Hearing Impairment  ___Neurological Impairment

Insect  ___Cardiac Conditions  ___IEP  ___504 plan  ___Orthopedic Concerns

Medication  ___Kidney/Urinary  ___Seizure Disorder  ___Shunt/Hydrocephalus

___ADHD  ___GI Conditions  ___Mental Health  ___Substance Exposed Newborn

___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) (For students ages 12 & older)  ☐ My Child May Self-Carry Cough Drops from Home

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: _______________________  Ph: _______________________

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

PARENT/GUARDIAN SIGNATURE: ___________________________________________  DATE: ______________________________