

Phone 410-276-6534 /Fax 410-276-6915

Consent for the Administration of Over the Counter Medications for the 2018-2019 school year

[**This form must be signed by both the parent/Guardian AND the healthcare provider**]

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_

Known Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any chronic condition[s] your child may have:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any long-term medication[s] your child receives:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for my child to receive the medications checked below on this form when appropriate. Either the School Nurse or the Medication Technician in concert with the School Nurse will administer the medication. I understand that generic equivalent medications may be used.

**Coughs/Sore Throats (Mild)**

\_\_\_\_\_\_\_\_Cough Drops [by mouth]

\_\_\_\_\_\_\_\_Vicks VapoRub [topical application to chest]

**For Cuts, Scrapes, and Minor Burns [**topical application**]:**

**\_\_\_\_\_\_\_\_**Triple Antibiotic Ointment; First Aid Burn Cream

**Muscle Aches** [topical application]:

\_\_\_\_\_\_\_\_\_BenGay Gel

**Minor Mouth Irritation** [topical application]:

\_\_\_\_\_\_\_\_Anbesol [pain relief for toothaches, oral irritation]; Campho-Phenique [pain relief for cold sores], GlyOxide [antiseptic cleanser for orthodontic appliance irritation, canker sores]

**Skin Irritation/Itching/Bee Sting** [topical application]:

\_\_\_\_\_\_\_\_\_Calamine Lotion, Benadryl Kids Anti-Itch Gel, Hydrocort with Aloe, Sting-Kill

\_\_\_\_\_\_\_\_ I DO NOT want any Over the Counter Medications [OTC] administered to my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider Signature Date Office Number

Consentimiento para la administración de medicamentos sin receta para el año escolar 2017-2018

Nombre del Estudiante: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grado: \_\_\_\_

Alergias conocidas: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enumere cualquier condición crónica que su hijo/hija pueda tener: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enumere cualquier medicamento de uso prolongado que su hijo/hija reciba: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doy permiso para que mi hijo/hija reciba los medicamentos marcados a continuación en este formulario, cuando sea apropiado. La enfermera de la escuela o el técnico de la medicación (de acuerdo con la enfermera de la escuela), administrará el medicamento. Entiendo que se pueden usar medicamentos genéricos equivalentes.

Para Tos / Dolor de garganta (ligero)

\_\_\_\_\_\_\_\_\_ Pastillas para la Tos [por la boca]

\_\_\_\_\_\_\_\_\_   Vicks Vapor Rub [aplicación tópica en el pecho]

Para cortes, raspaduras y quemaduras menores [aplicación tópica]:

\_\_\_\_\_\_\_\_    Ungüento Antibiótico Triple, Crema de primeros auxilios para quemaduras

Para Dolores musculares [aplicación tópica]:

\_\_\_\_\_\_\_\_\_  BenGay Gel

Para Irritación ligera de la boca [aplicación tópica]:

\_\_\_\_\_\_\_\_    Anbesol [para los dolores de dientes, irritación oral]

\_\_\_\_\_\_\_\_    Campho-Phenique [para el dolor de herpes labial]

\_\_\_\_\_\_\_\_    GlyOxide [antiséptico para la irritación del aparato ortodóntico)

Para Irritación de la Piel / Picazón / Picadura de abeja [aplicación tópica]:

\_\_\_\_\_\_\_\_    Loción Calamina

\_\_\_\_\_\_\_\_   Benadryl para Niños

\_\_\_\_\_\_\_\_   Hydrocort con Aloe

\_\_\_\_\_\_\_\_   Sting-Kill

\_\_\_\_\_\_\_\_       No quiero que se le administren a mi hijo/hija medicinas sin receta médica.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma del Padre/Guardian   Fecha Número de Teléfono

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma del Proveedor de Servicios Médicos Fecha Número de teléfono de la Oficina