BALTIMORE COUNTY PUBLIC SCHOOLS
Office of Health Services

Consent for Administration of Approved Discretionary Medications and Health Contact Information

Last Name:_____ **First Name:**_____ **Date of Birth:**_____

School: _____ **Grade /Teacher:** _____

Allergies (include all allergies): _____

List all medications your child receives on a regular or as needed basis: _____

_____

Medical/Health Problems: My child is followed by a healthcare provider for: (Check all that apply)

☐ Asthma ☐ ADHD ☐ Diabetes ☐ Migraines ☐ Seizures ☐ Other (describe) _____

Is there a health problem that would prevent full participation in the school program or physical education program?

☐ No ☐ Yes Describe _____

I would like the following medication(s) made available to my child: *(please check)*

- ☐ **Acetaminophen** *(like Tylenol) for headache/fever/burns/earache/muscle aches/pain/menstrual cramps*
- ☐ **Chewable Antacid Tablets** *(like Tums) for upset stomach*
- ☐ **Cough Drops** *for cough/sore throat*
- ☐ **Diphenhydramine** *(like Benadryl) for mild allergic reactions*
- ☐ **Ibuprofen** *(like Advil) for headache/fever/burns/earache/muscle aches/pain (age 12 and older) or menstrual cramps (age 9 and older)*
- ☐ **Zinc Oxide** *for diaper rash*
- ☐ **I do not want any medication given to my child in school.** *Note: Epinephrine and Naloxone are stock medications and will be administered to student in an emergency if needed.*

Contact Information

Parent/Guardian 1 Name: _____ Parent/Guardian 2 Name: _____

Parent/Guardian 1 Home Phone:_____ Parent/Guardian 2 Home Phone:_____

Parent/Guardian 1 Cell: _____ Parent/Guardian 2 Cell: _____

Parent/Guardian 1 Work: _____ Parent/Guardian 2 Work: _____

Parent/Guardian 1 EMAIL:_____ Parent/Guardian 2 EMAIL: _____

Parent/Guardian Home Address _____

Persons to whom student may be released other than parent:

Name:_____ Phone Number(s):_____

Name:_____ Phone Number(s):_____

Do you need assistance in obtaining health insurance for your child? No ☐ Yes ☐

I understand that the above medications I have checked will be administered by the Registered Nurse/School Nurse in accordanc with established protocols developed by the Chief Physician of School Health Services for the Baltimore County Department o Health and the Coordinator of Health Services for Baltimore County Public Schools. I understand that generic equivalent o medications may be used. My signature authorizes the release of my child to the persons listed on this page.

_____ _____

Signature of Parent **Date**