GreatHearts
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Parental Consent Form to Dispense Medication - SY 2016/2017

I hereby request and give my consent for the school nurse or other designated staff to dispense the medication(s) noted below to my child. I acknowledge that school personnel are not responsible for any ill effects which might occur**. Note: The very first dose of this medication for current condition/illness may not be given at school.**

Student's Name (Please Print):_____ **Birthdate:**_____

Known Medication Allergies:_____ **Student's Weight:**_____

Non-Prescription Medications - School Stock

Advil: (200 mg/tablet)

age	dose	Mark (X)
12 years and older	1 tablet	
12 years and older	2 tablets	

May administer by mouth every 4-6 hours as needed for pain or fever.

☐ **DO NOT** dispense to my child

Tylenol: (325 mg/ tablet)

age	dose	Mark (X)
12 years and older	1 tablet	
12 years and older	2 tablets	

May administer by mouth every 4-6 hours as needed for pain or fever.

☐ **DO NOT** dispense to my child

Benadryl: (25 mg/ tablet)

age	dose	Mark (X)
12 years and older	1 tablet	
12 years and older	2 tablets	

May administer by mouth every 4-6 hours as needed for emergency allergic reaction.

☐ **DO NOT** dispense to my child

☐ **DO NOT DISPENSE ANY MEDICATION TO MY CHILD.**

Over-the-counter Medications – These are to be furnished by the parent, in the original container with student's name and dosage instructions provided. Medications to be administered more than 10 days must have a physician's order. Medications not picked-up within 10 days will be disposed of in accordance to federal guidelines. Expired medications or medications without proper dosage instructions **will not** be administered to student.

Name of Medication	Route (by mouth, etc.)	Dosage	Time	Possible Side Effects

Prescription Medications - **ALL** medications must be furnished by the parent in the original container with affixed prescription label. No more than a 30 day supply of medication should be brought to the health office. All controlled substances should be brought into the health office by a parent/guardian.

Name of Medication	Route (by mouth, etc.)	Dosage	Time	Expected Duration	Prescriber's Name	Indication for treatment	Possible Side Effects

Special Requirements (example: take with food**):**_____

Signature of Parent/Guardian:_____ **Date:** _____

Rev. 08/16