Carroll County Public Schools
Health Services

Consent for Administration of Approved Discretionary Medications

Student Name:_____ **Date of Birth**:_____ **School**:_____ **Grade/Teacher**:_____

Allergies (include medication allergies):_____

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

Medical/Health Problems: Check all that apply

☐ Asthma ☐ ADHD ☐ Bleeding Disorder ☐ Diabetes ☐ Heart Problem ☐ Migraines ☐ Seizures ☐ Vision (wears glasses) ☐ 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)

For Headache/Fever/Burns/Muscle Aches/Pain/Menstrual Cramps

☐ Acetaminophen (*like Tylenol*) ☐ Ibuprofen (*like Advil*)

I understand that the above medications I have checked will be administered by the Registered Nurse/School Nurse in accordance with established protocols developed by the Deputy Health Officer of Carroll County Department of Health and the Supervisor of Health Services for Carroll County Public Schools. I understand that equivalent generic of medications may be used.

_____ _____ _____

Signature of Parent/Guardian Primary Phone Number Date

Reviewed by Nurse_____ Date_____

Initial _____ **Name**_____ **Initial** _____ **Name**_____ **Initial** _____ **Name**_____

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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