Carroll County Public Schools

Annual Consent for Administration of Discretionary Medications

Dear Parent or Guardian:

On the reverse side of this letter is a form that provides the school nurse with updated health information on your child and a section to indicate your consent for the administration of certain nonprescription medications which are available, at no charge, for all students. **This form must be filled out each school year.**

The nonprescription medication program (called Discretionary Medications) is designed to alleviate minor discomforts and to prevent unnecessary early dismissals from school. These medications are approved by the Deputy Health Officer of Carroll County Health Department, and the Supervisor of Health Services, Carroll County Public Schools.

Your consent must be obtained each time before any medication is given to your child. The school nurse will contact you to verify time of last dose. If nurse is unable to reach you, no medication will be administered. Only the School 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.

Approved discretionary medications are intended for occasional use only. If your child requires any prescription or nonprescription medication on a regular basis, is under the care of a Health Care Provider, or has a diagnosed injury/condition or chronic health concern, 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,

Filipa Gomes, MSN, RN
Supervisor Office of Health Services
Carroll County Public Schools

7/2018

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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8/2017