



Medication Consent School Year 2024-2025

According to the guidelines issued by the Pennsylvania Department of Health, in order to dispense any prescription or non-prescription medication we must have this consent signed by a parent/guardian and a licensed prescriber.

Please check the appropriate lines below, sign and return to school. Your daughter will not be given medication including over the counter (OTC) medication without this completed form.

STUDENT'S NAME: _____ Date of Birth: _____

OTC Medication

_____ Tylenol 325 mg 1-2 tablets by mouth every 4 hours as needed

_____ Advil 200 mg 1-2 tablets by mouth every 6 hours as needed

_____ Tums or Gelusil 1-2 tablets chew for upset stomach or acid reflux PRN

_____ Other: (must be supplied by student to keep in nurse's office)

PRESCRIPTION MEDICATION

Medication dose and time:

Student is authorized to self-administer emergency medication (EpiPen/ Inhaler): yes no

_____	_____	_____
Date	Doctor's Signature	Office phone number
_____	_____	_____
Date	Parent's Signature	Phone number