Malden Public Schools

School Health Services

Parent/Guardian Consent form for Medication Administration

OVER THE COUNTER MEDICATIONS

****for Malden High School Students only****

Student Name: Last _____ First_____

Date of Birth _____ Grade: _____

Medication Allergies: _____

Other allergies: _____

Additional health information or other medications taken: _____

_____

Please check off the following medications that may be given to your child at school:

- ☐ Acetaminophen/Tylenol 325 mg 1-2 tablets every 4-6 hours as needed
- ☐ Ibuprofen/Motrin 200mg 1-2 tablets every 4-6 hours as needed
- ☐ Benadryl/Diphenhydramine HCL 25 mg - 1-2 tablets as needed
- ☐ Tums 1-2 tablets (40-80mg) 1-2 tablets as needed

I give permission for the school nurse to give the following medications for the **2025/26** school year when it is necessary.

Signature _____

Phone number_____ Date_____

Kathy Donahue RN 781-388-6003
Sheila Butler RN 781-397-6005
Jillian Gay RN 781-397-6004

Malden High School
Nurse's Office
77 Salem St.
Malden, MA 02148