DAVIDSON ACADEMY

2010-2011 Medication Consent

Student's Name_______________________________________ **2010-2011 Grade**______

D.O.B.__________

The Health Department requires a parental signature for medication administration. As the school nurse, with your permission, I will administer certain medications on an "as need" basis that are stocked in the clinic. Medications will not be administered without parental consent.

Please complete and sign the form below designating the medications you may request to be administered by the school nurse or individual designated by the school nurse. Written consent on file will allow legal administration of over-the-counter medications in your absence. This consent form will be in effect for the current school and will be renewed ANNUALLY.

Allergies____

Chronic Medical Conditions ____

____

____

Daily Medications ____

____

During school hours the school nurse, or individual designated by the school nurse, has my permission to administer any of the checked medications below that I have requested for ____ **(Name of Student)**.

Please place an X beside the medications you request to be administered when needed:

___ Tylenol (Acetaminophen)
___ Motrin (Ibuprofen
___ Mylanta for stomach upset
___ Tums for stomach upset
___ Hydrocortisone 1% for itching
___ Caladryl Clear for itching
___ Antibiotic ointment
___ Tussin DM for cough
___ Benadryl for allergy symptoms
___ Sudafed for nasal congestion
___ Cough drop for ages 7 and over
___ Other ____

Parent/Guardian Signature ____ **Date** ________________

Phone Numbers: Mother home ______________________ Father home ________________________
Mother day ________________________ Father day __________________________
Mother cell ________________________ Father cell __________________________

Emergency Contact ____

Other Numbers ____