

BALTIMORE COUNTY PUBLIC SCHOOLS
Office of Health Services

**Consent for Administration of Approved Discretionary Medications and
Health Contact Information**

Last Name: _____ First Name: _____ Date of Birth: _____

School: _____ Grade /Teacher: _____

Allergies (include all allergies): _____

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

Medical/Health Problems: My Child is followed by a healthcare provider for: (Check all that apply)

Asthma ADHD Diabetes Migraines Seizures 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/Earache/Muscle Aches/Pain/Menstrual Cramps

Acetaminophen (like Tylenol)

Ibuprofen (like Advil)
(age 12 and older/age 9 for menstrual cramps)

For Upset Stomach

Chewable Antacid Tablets
(like Tums)

For Mild Allergic Reactions

Diphenhydramine (like Benadryl)

For Coughs/Sore Throats

Cough Drops

For Diaper Rash

Zinc Oxide

I do not want any medication given to my child in school.

Contact Information

Parent/Guardian 1 Name: _____ Parent/Guardian 2 Name: _____

Parent/Guardian 1 Home Phone: _____ Parent/Guardian 2 Home Phone: _____

Parent/Guardian 1 Cell: _____ Parent/Guardian 2 Cell: _____

Parent/Guardian 1 Work: _____ Parent/Guardian 2 Work: _____

Parent/Guardian 1 EMAIL: _____ Parent/Guardian 2 EMAIL: _____

Parent/Guardian Home Address: _____

Persons to whom student may be released other than parent:

Name: _____ Phone Number(s): _____

Name: _____ Phone Number(s): _____

Do you need assistance in obtaining health insurance for your child? No Yes

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 Chief Physician of School Health Services for the Baltimore County Department of Health and the Coordinator of Health Services for Baltimore County Public Schools. I understand that generic equivalent of medications may be used. My signature authorizes the release of my child to the persons listed on this page.

Signature of Parent _____

Date _____