

BALTIMORE COUNTY PUBLIC SCHOOLS
Office of Health Services

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

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) _____

I would like the following medication(s) made available to my child: *(please check)*

For Headache/Fever/Burns/Earache/Muscle Aches/Pain/Menstrual Cramps

For Upset Stomach

Acetaminophen *(like Tylenol)*

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

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): _____

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/Guardian/Eligible Student

Date

**Annual Consent for Administration of Discretionary Medications
And Health Contact Information**

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, a list of persons to be contacted in the case of an illness or injury 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 Chief of School Health Services, Baltimore County Department of Health, and the Coordinator, Office of Health Services, Baltimore County Public Schools.

Your consent must be obtained before any medication is given to your child. Only the Registered Nurse/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, 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,

Deborah Somerville, RN, MPH
Coordinator
Office of Health Services
Baltimore County Public Schools

Lucia Donatelli, MD, FAAP
Chief
Bureau of Child, Adolescent and School Health
Baltimore County Department of Health