

OUR LADY OF PERPETUAL HELP SCHOOL
CONSENT FOR MEDICATION ADMINISTRATION
20____ TO 20____

Student's Name

Homeroom Teacher & Number

I hereby request and give my consent for the school nurse or person designated by the administrator to see my child who receives the following medication for the period from _____ to _____.

The medication is to be furnished by me IN THE ORIGINAL CONTAINER and is to be labeled with and given in the following manner:

1) PRESCRIPTION medication and number: _____

- Prescriber's Name (must be on label) _____
- Route of administration (by mouth, etc.) _____
- Amount to be given _____
- Time of day to be taken _____
- Duration of treatment _____
- Reason for medication _____

2) NON PRESCRIPTION (state how much and how often):

- acetaminophen (e.g. Tylenol) _____
- ibuprofen (e. g. Motrin, Advil) _____
- diphenhydramine (e.g. Benadryl) _____
- topical (cream, lotion) _____
- cough drops _____
- other _____

Comments _____

Date

Signature

Printed Name

Any CHANGES in medication
must be submitted to the Health Office
IN WRITING.

