

Mary McDowell Friends School  
**MEDICATION INFORMATION & CONSENT FORM**  
 2011-2012 Academic Year

NAME OF CHILD \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

**NOTE: This form must be signed by both a physician and student's parents**

- *For your child's safety it is important for the School to know all the medications that your child is taking, and if staff are permitted to administer medications to your child in school and on school organized overnight trips. A new form must be completed every time you change medication or modify the dosage.*
- *Please notify the school office if you require an additional form.*
- *This form must be completed and returned to the school nurse, even if your child is not taking any medication.*
- *This information will also be used for overnight trips.*
- *If there are any changes it is the parent's responsibility to submit a new form with both a parent and a physician's signature.*

**INDICATE BELOW IF YOU GIVE THE SCHOOL PERMISSION TO ADMINISTER THE FOLLOWING DOCTOR PRESCRIBED MEDICATION:**  
 (Check the appropriate box)

EPIPEN	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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**INDICATE BELOW IF YOU GIVE THE SCHOOL PERMISSION TO ADMINISTER THE FOLLOWING OVER THE COUNTER MEDICATION:**  
 (Check the appropriate box)

Antihistamines (including Benadryl) in Pill/Liquid Form	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tylenol/Advil	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistamine Nasal Sprays	<input type="checkbox"/> Yes <input type="checkbox"/> No	Corticosteroid Nasal Sprays	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistamine eye drops	<input type="checkbox"/> Yes <input type="checkbox"/> No		

*Special instructions:*

**My child is NOT taking ANY Medications**   

**My child IS taking the following medications:**

<i>Name of medication</i>	<i>dose</i>	<i>time/s of day given</i>
<i>Name of medication</i>	<i>dose</i>	<i>time/s of day given</i>
<i>Name of medication</i>	<i>dose</i>	<i>time/s of day given</i>

**THE SCHOOL HAS PERMISSION TO ADMINISTER THE ABOVE MEDICATIONS ON AN OVERNIGHT TRIP**     Yes     No

**THE SCHOOL HAS PERMISSION TO ADMINISTER THESE MEDICATIONS IN A TIME OF CRISIS**     Yes     No

<i>Parent's Name</i>		<i>Physician's Name</i>
<i>Parent's Signature</i>	<i>Physician's Stamp</i>	<i>Physician's Signature</i>
<i>Date</i>		<i>Date</i>

***Turn over if in school medication request needed***

## REQUEST FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

*In order to administer medication to your child during the school day we need:*

*From you -*

- *Your permission*

*From the attending physician:*

- *Detailed instructions which are signed*
- *Advice as to any possible side effects or indications that the medication should be withheld*
- *The proper procedure should there be an emergency related to the medication.*

*We will make every reasonable effort to comply with this request.*

<i>Medication name</i>	<i>Dose</i>	<i>Time given</i>
<i>Medication name</i>	<i>Dose</i>	<i>Time given</i>
<i>Medication name</i>	<i>Dose</i>	<i>Time given</i>

**I GIVE THE SCHOOL PERMISSION TO ADMINISTER THE DOCTOR PRESCRIBED MEDICATION TO MY CHILD DURING THE SCHOOL DAY AS LISTED ABOUT:**

<i>Parent Name</i>	<i>Parent Signature</i>	<i>Date</i>
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**SIDE EFFECTS**

**PROCEDURES IN A MEDICATION RELATED EMERGENCY:**

**I REQUEST THAT THE SCHOOL ADMINISTER THE MEDICATION PRESCRIBED ABOVE:**

<i>Physician's Name</i>	<i>Physician's Signature</i>	<i>Date</i>
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*Physician's Stamp*