

St. James Academy Health Suite

Consent for Administration of Approved Discretionary Medications

Student's Name: _____ Date of Birth: _____ Grade: _____

Medication Allergies/Sensitivities: _____

List any medication your child receives at home: _____

Medical/health problems: _____

I give permission for my child to receive any medication listed below on this form as deemed necessary by the Registered Nurse-School Nurse. I understand that generic equivalent medications may be used. I understand that the medications I have checked will be administered in accordance with established protocols and the School Nurse's discretion. I understand that I will be notified when discretionary medication has been administered at school.

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)

For Upset Stomach

Chewable Antacid (like Tums)

For Mild Allergic Reactions

Diphenhydramine (like Benadryl)

For Coughs/Sore Throats

Cough Drops

For Bee Stings

Baking Soda Paste

For Skin Itching/Irritation

Caldyphen Clear (like Calamine Lotion)

Hydrocortisone 0.5%

Alternate Option

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

Please Sign and Return to the Health Suite.

Signature of Parent/Guardian

Date