BOSTON PUBLIC SCHOOLS
CONSENT FORM FOR
ADMINISTRATION OF APPROVED MEDICATIONS

NAME: ______________________________ Date of Birth: ____________________

SCHOOL: ____________________________ Grade/Room: ____________________

Is student allergic or sensitive to any medications? If yes, which ones? ____________________

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Any medical/health problems? ____

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List any long-term medication/s your child receives ____________________________

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I give permission for my child ______________________________ to receive the medication/s listed below as deemed necessary by the School Nurse. I understand that a generic equivalent medication may be used. I understand that **ONLY the school nurse**, in accordance with established written protocols, will administer the medication/s I have checked. Please contact the school nurse with any questions or concerns.

1. For menstrual cramps
   - ☐ ibuprofen tablets (Advil, Motrin)
   - ☐ acetaminophen tablets (Tylenol)

2. For headache
   - ☐ ibuprofen tablets(Advil, Motrin)
   - ☐ acetaminophen tablets(Tylenol)

3. For itching
   - ☐ benadryl liquid/tablets
   - ☐ calamine lotion/other topicals

______________________________ Signature of parent/guardian

______________________________ Date

______________________________ Home Phone#

______________________________ Work Phone #

______________________________ Emergency Phone #

6/12/2003