

Carroll County Public Schools  
Health Services

**Consent for Administration of Approved Discretionary Medications**

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) \_\_\_\_\_

Is there a health problem that would prevent full participation in the school program or physical education program?

- No  Yes Describe: \_\_\_\_\_

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

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

- Acetaminophen (*like Tylenol*)  Ibuprofen (*like Advil*)

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 Deputy Health Officer of Carroll County Department of Health and the Supervisor of Health Services for Carroll County Public Schools. I understand that equivalent generic of medications may be used.

\_\_\_\_\_  
Signature of Parent/Guardian Primary Phone Number Date

Reviewed by Nurse \_\_\_\_\_ Date \_\_\_\_\_

Initial	Name	Initial	Name	Initial	Name																											
Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
August																																
September																																
October																																
November																																
December																																
January																																
February																																
March																																
April																																
May																																
June																																
July																																