MEDICATION PERMISSION FORM

Parent Authorization - OVER-THE-COUNTER MEDICATION

The following OTC (over the counter) medications are available in our Health Suite. They are dispensed by school personnel with the goal of keeping your student comfortable, so they may remain in school. **These medications DO NOT require a health care provider's signature. Medication will be dispensed according to the manufacturer's recommended dosage. Please check the medications that you wish to have administered to your child.**

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil & Motrin) ☐Benadryl ☐ Mylanta/Tums
☐ Throat lozenges/cough drops

Student's name:______________________________________**DOB**__________**Grade**______

I (print parent/guardian name) _________________________________hereby give my consent for my child/student identified above to receive medication as dispensed/prescribed and I release AFS of all responsibility for any benefit and any and all adverse consequences of the medication. I also give consent for Abington Friends School Health Services Staff to communicate with our Health Care Provider for the benefit of my child/student.

Date_______________ Parent/Guardian Signature____________________________________

Health Care Provider Authorization - PRESCRIPTION MEDICATION

When medication is required during school hours the parent/guardian or responsible adult must bring the medication to the Nurse's Office prior to the prescription medication being administered to the student. It **must** be in its original container properly labeled by the pharmacy **and accompanied by this form to be completed by your student's healthcare provider. The school nurse may only administer medication prescribed by a healthcare provider.**

Diagnosis:____

Medication #1 ___________________________________**Dosage**________________________

Frequency:__________________**Start Date:** _______________ **End Date:**______________
Medication #2____________________________________**Dosage**________________________

Frequency:__________________**Start Date:** _______________ **End Date:**______________

Inhaler or Epinephrine Auto Injector: **Is student is authorized to carry/self administer?**
Yes___**No**___

Health Care Provider Signature:____

Telephone:__________________________________**Date:**______________________________