

AL-RAHMAH SCHOOL

Consent for Administration of Approved Discretionary Medications

Health Contact Information

School Year  2020-2021  2021-2022  2022-2023

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ 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 only** the medications that were taken before by your child)

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

**For Upset Stomach**

Acetaminophen (like Tylenol)  Ibuprofen (like Advil)  Chewable Tablets Antacid (like TUMS)  
(Age 4 and older/age 9 for menstrual cramps) (Age 4 and older)

**For Mild Allergic Reactions**

**Cuts/Wounds/Scratches/Minor Skin Irritation**

Diphenhydramine (like Benadryl)  Vaseline  Topical antibiotic ointment (like Neosporin)

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

**Contact Information**

Parent/Guardian 1 Name: \_\_\_\_\_ Parent/Guardian 2 Name: \_\_\_\_\_

Parent/Guardian 1 Home Phone: \_\_\_\_\_ Parent/Guardian 2 Home Phone: \_\_\_\_\_

Parent/Guardian 1 Cell: \_\_\_\_\_ Parent/Guardian 2 Cell: \_\_\_\_\_

Parent/Guardian 1 Work: \_\_\_\_\_ Parent/Guardian 2 Work: \_\_\_\_\_

Parent/Guardian Home Address: \_\_\_\_\_

Persons to whom student may be released other than parent:

Name: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number(s): \_\_\_\_\_

I acknowledge that my child had taken the above medications I have checked and had no allergic reactions to them. I understand that the above medications I have checked will be administered by the Registered Nurse in accordance with established protocols developed for Al-Rahmah School under the authorization of Dr. N'Dama Bamba. I understand that generic equivalent of medications may be used. My signature authorizes the release of my child to the persons listed on this page.

Signature of Parent/Guardian/Eligible Student \_\_\_\_\_ Date \_\_\_\_\_