MOUNT LAUREL SCHOOLS
CONSENT FOR ADMINISTRATION OF APPROVED MEDICATION

Name: _____ Date of Birth: _____

School: _____ Teacher: _____

Medication Allergies/Sensitivities: _____

Current Daily Medication: _____

Medical/Health Problems: _____

I give permission for my child, _____ to receive any medication checked below on this form deemed necessary by the Registered Nurse/School Nurse. Dosage will be calculated by the dose recommendations already labeled on the medication according to the child's weight and age. I understand that generic equivalent medications may be used.

I would like the following medication(s) made available to my child: **(Please Check)**

For Headache/Burns/Earache/Muscle Aches/Pain/Menstrual Cramps:

_____ Tylenol

_____ Throat lozenge or cough drop. (Limit 2 per day)

_____ Chewable antacid. (Limit 1 per day)

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 Chief School Physician and in accordance to Mount Laurel Medication Policy.

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

_____ _____

Parent/Guardian Signature **Date**