Dear Parent or Guardian:

On the reverse side of this letter is a form that provides the school nurse with updated health information on your child, a list of persons to be contacted in the case of an emergency and a section to indicate your consent for the administration of certain nonprescription medications which are available, at no charge, for all students. **This form must be filled out each school year.**

The nonprescription medication program (called Discretionary Medications) is designed to alleviate minor discomforts and to prevent unnecessary early dismissals from school. These medications are approved by the Chief of School Health Services, Baltimore County Department of Health, and the Coordinator, Office of Health Services, Baltimore County Public Schools.

Your consent must be obtained before any medication is given to your child. Only the Registered Nurse/School Nurse may administer these medications in accordance with established protocols. The consent form lists the medications which may be available. Please complete the consent form, and return it to the school nurse.

Approved discretionary medications are intended for occasional use only. If your child requires any prescription or nonprescription medication on a regular basis, you must obtain a written order from your health care provider and supply the medications.

If you have any questions or would like further information, please contact your school nurse.

Sincerely,

Deborah Somerville, RN, MPH
Coordinator
Office of Health Services
Baltimore County Public Schools

Lucia Donatelli, MD, FAAP
Chief
Bureau of Child, Adolescent and School Health
Baltimore County Department of Health
# Consent for Administration of Approved Discretionary Medications and Health Emergency Contact Information

## Student Information
- **Student Name:**
- **School:**
- **Date of Birth:**
- **Grade:**

## Allergies
- **Allergies (include Medication allergies):**
- **List all medications your child receives on a regular basis:**

## Medical/Health Problems
- **Medical/Health Problems: Check all that apply**
  - [ ] Asthma
  - [ ] ADHD
  - [ ] Bleeding Disorder
  - [ ] Diabetes
  - [ ] Heart Problem
  - [ ] Migraines
  - [ ] Seizures
  - [ ] Other (describe)

## Modifications Needed at School
- **Modifications Needed at School: Check all that apply**
  - [ ] Special Seating
  - [ ] Modified Physical Education
  - [ ] Other (describe)

## Medications
- **I would like the following medication(s) made available to my child: (please check)**
  - **For Headache/Fever/Burns/Earache/Muscle Aches/Pain/Menstrual Cramps**
    - [ ] Acetaminophen (like Tylenol)
    - [ ] Ibuprofen (like Advil)
    - [ ] Chewable Antacid Tablets (age 12 and older/age 9 for menstrual cramps)
  - **For Upset Stomach**
    - [ ] Cough Drops
  - **For Mild Allergic Reactions**
    - [ ] Diphenhydramine (like Benadryl)
  - **For Coughs/Sore Throats**
    - [ ] Cough Drops

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

## Emergency Contact Information
- **Parent/Guardian 1 Name:**
- **Parent/Guardian 1 Home Phone:**
- **Parent/Guardian 1 Cell:**
- **Parent/Guardian 1 Work:**
- **Parent/Guardian 2 Name:**
- **Parent/Guardian 2 Home Phone:**
- **Parent/Guardian 2 Cell:**
- **Parent/Guardian 2 Work:**

- **Persons to Whom Student May be released other than parent:**
  - **Name:**
  - **Phone Number(s):**

## Signature
- **Signature of Parent/Guardian/Eligible Student:**
- **Date:**

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*BEBCO 0881-08*