HCPS

HARFORD COUNTY PUBLIC SCHOOLS
A.A. Roberty Building
102 S. Hickory Ave.
Bel Air, Maryland 21014

HARFORD COUNTY HEALTH DEPARTMENT
120 South Hays Street
Bel Air, Maryland 21014

CONSENT FOR ADMINISTRATION OF APPROVED DISCRETIONARY MEDICATIONS 2020-2021

Dear Parent/Guardian:

On the reverse side of this letter is a consent form for the administration of certain nonprescription/over-the- counter medications which will be available, at no charge, for all students. This service is available to alleviate your student's minor discomforts and to avoid early dismissals from school. These medications are approved by the Harford County Health Department and the Supervisor of Health Services for Harford County Public Schools. This service helps our students improve attendance and enhance academic performance. Please note that there will be a limited supply of cough drops this school year. You may signify your permission to have your student self-carry cough drops from home by checking the appropriate box.

Your consent must be obtained before any medication is given to your student. Only the Registered Nurse/Licensed Practical 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. The consent is in effect for this school year only and will need to be renewed at the beginning of each school year.

Approved discretionary medications are intended for occasional use only. Discretionary medication will administered at the **discretion of the school nurse**. If your student 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,

Dr. Russell Moy, MD, MPH
Deputy Health Officer
Harford County Health Department

Mary Nasuta, RN, MS, NCSN
Supervisor of Health Services
Harford County Public Schools

Office Use Only

rev. 7/20

HCPS

HARFORD COUNTY PUBLIC SCHOOLS HEALTH SERVICES

DISCRETIONARY MEDICATION FORM 2020-2021

Student Name: _____ DOB: _____ M / F: ____ Gr: _____
Last First MI

Student Weight: _____ Homeroom Teacher: _____ Bus #_____ Walker: ____ Car: ____ Drives: _____

Address: _____ Home Phone: _____
Street Town Zip Code

Medication Allergies/Sensitivities: _____

List ALL Medications your student takes on a regular basis: _____

Reason for Medication(s): _____

Physician: _____ Phone: _____ Dentist: _____ Phone: _____

MEDICAL/HEALTH PROBLEMS: Check all that apply.

___Severe Allergy**
- Food _____
- Insect _____
- Medication _____

___Asthma __ Rescue Inhaler
___ADHD
___Bleeding Disorder
___Cancer
___Cardiac Conditions
___Diabetes
___Genetic Disorder
___GI Conditions
___Glasses ___Contacts
___Hearing Impairment
___IEP ___504 plan
___Kidney/Urinary
___Loss of Vision ___Blind
___Mental Health
___Migraines
___Neurological Impairment
___Orthopedic Concerns
___Seizure Disorder
___Shunt/Hydrocephalus
___Substance Exposed Newborn
___Other_____

If yes, explain: _____

** IF Severe Allergy Noted Above – Student Uses: EpiPen® _____ Benadryl® _____ No Medication_____ Other Medication (severe allergy only) _____

MEDICATION ADMINISTRATION:

I give permission for my student to receive any medication listed below on this form as deemed by the Registered Nurse/Licensed Practical Nurse. I understand that a generic equivalent may be used.

I would like the following medication(s) made available to my student. (Please check)

For Upset Stomach

☐ Chewable Antacid Tablets (Like Tums)

My Child May Self-Carry Cough Drops from Home

☐ (For students >5 y/o. There will be a very limited supply of cough drops in the health suite.)

For Headache/Fever/Burns/Earache/Sore Throat

☐ Acetaminophen (like Tylenol)

For Musculoskeletal Injury/ Menstrual Cramps/Headache

☐ Ibuprofen (like Advil –for students ages 12 & older)

☐ I do NOT want any medication given to my student in school.

I understand that the above medications I have checked will be administered by the Registered Nurse/Licensed Practical Nurse in accordance with established protocols developed by the Deputy Health Officer, Harford County Health Department and the Supervisor of Health Services for Harford County Public Schools.

PARENT/GUARDIAN INFORMATION:

Parent/Guardian #1: _____ **(H) Ph:** _____ **(C) Ph:** _____ **(W) Ph:** _____

Parent/Guardian #2: _____ **(H) Ph:** _____ **(C) Ph:** _____ **(W) Ph:** _____

Parent/Guardian email: _____

IF PARENT/GUARDIAN CANNOT BE REACHED ONLY LISTED PERSONS WILL BE CONTACTED AND PERMITTED TO PICK UP STUDENT

Name: _____ **Relationship:** _____ **Ph:** _____ **Ph:** _____

Name: _____ **Relationship:** _____ **Ph:** _____ **Ph:** _____

***ALL INFORMATION MAY BE SHARED WITH STAFF AND/OR TRANSPORTATION ON A NEED-TO-KNOW BASIS UNLESS OTHERWISE NOTIFIED.**

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____