Medication Consent
School Year 2026-2027

According to the guidelines issued by the Pennsylvania Department of Health, in order to administer any prescription or non-prescription drugs, we must have this consent completedand signed by a parent/guardian and a licensed prescriber.

Please check the appropriate lines below, sign and return to school. Your daughter will not be given medication including over the counter (OTC) medication without this completed form.

STUDENT'S NAME:________________________________Date of Birth: ___________

OTC Medication

________Tylenol 325 mg 1-2 tablets by mouth every 4 hours as needed

________Advil 200 mg 1-2 tablets by mouth every 6 hours as needed

________Tums or Gelusil 1-2 tablets chew for upset stomach or acid reflux PRN

________Antihistamine (Diphenhydramine 25-50 mg or Cetirizine 10 mg one dose only)

PRESCRIPTION MEDICATION

Medication with dose, route, frequency and time:

____

____

____

Student is authorized to self-administer emergency medication (Epi auto-injectors/inhalers):
☐ yes ☐ no

______________________________ ______________________
Doctor's Name (Printed) Office phone number

______________ ______________________________
Date **Doctor's Signature**

______________ ______________________________
Date **Parent's Signature**