



Medication Administration Consent Form - Grades 7-12 2009-10

Student Name _____ Grade _____

Medication Allergies _____

Current Medication _____

Chronic Medical Conditions _____

Past Surgeries _____

I understand that the PCA clinic will provide students in grades 7-12 with selected over-the-counter medications or their generic equivalent if needed. I understand that all other medications – prescription and over-the-counter – must be sent to school by me (the parent or guardian) in the original container and kept in the Upper School clinic. I understand that PCA students are not allowed to self-administer medications while at school.

Below, please indicate which over-the-counter medications you consent to being given to your student in grades 7-12 in the clinic during school hours.

| | Don't Allow | | | Don't Allow | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| Allow | Allow | Medication | Allow | Allow | Medication |
| <input type="checkbox"/> | <input type="checkbox"/> | Advil/Motrin (Ibuprofen) | <input type="checkbox"/> | <input type="checkbox"/> | Naphcon Eye Drops |
| <input type="checkbox"/> | <input type="checkbox"/> | Aleve (Naproxen sodium) | <input type="checkbox"/> | <input type="checkbox"/> | Orajel |
| <input type="checkbox"/> | <input type="checkbox"/> | Benadryl (Diphenhydramine HCl) (only for observed allergic reactions) | <input type="checkbox"/> | <input type="checkbox"/> | Pepto-Bismol |
| <input type="checkbox"/> | <input type="checkbox"/> | Calamine Lotion | <input type="checkbox"/> | <input type="checkbox"/> | Polysporin Ointment |
| <input type="checkbox"/> | <input type="checkbox"/> | Cepacol Sore Throat Spray | <input type="checkbox"/> | <input type="checkbox"/> | Sudafed (Pseudoephedrine) PE |
| <input type="checkbox"/> | <input type="checkbox"/> | Cepacol Throat Lozenges | <input type="checkbox"/> | <input type="checkbox"/> | Robitussin DM Cough Formula (parents will be called each time.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Dimetapp Cold and Allergy (parents will be called each time.) | <input type="checkbox"/> | <input type="checkbox"/> | Tears Naturale Lubricant Eye Drops |
| <input type="checkbox"/> | <input type="checkbox"/> | Halls Menthol Eucalyptus Cough Drops | <input type="checkbox"/> | <input type="checkbox"/> | Topical Oral Anesthetic (Anbesol) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hydrocortisone Cream 1% | <input type="checkbox"/> | <input type="checkbox"/> | Tylenol (Acetaminophen) |
| <input type="checkbox"/> | <input type="checkbox"/> | Icy Hot Analgesic Balm | <input type="checkbox"/> | <input type="checkbox"/> | Tums |
| <input type="checkbox"/> | <input type="checkbox"/> | Imodium AD | | | |

I (We) agree to hold harmless and indemnify PCA and its representatives for any liability sustained by school as the results of the negligent, or willful acts of the student, or as a result of the misrepresentation of information given by the student about the administration of medications received at home. I understand that it is my responsibility as the parent or guardian of this student to immediately notify the PCA clinic of any changes in my child's medical condition, medication allergies, daily medications received or situations which may alter the safety of the administration of these medications while at school.

Parent/Guardian Signature _____ Date _____