MEDICAL CONSENT FORM

School Year 2023–2024

Student Name: _____ **DOB:** _____

Allergies? ☐ Yes ☐ No

If yes, to what: _____

If yes, is student prescribed an EpiPen? ☐ Yes ☐ No

Is it self-carry/self-administer? ☐ Yes ☐ No

Asthma? ☐ Yes ☐ No

If yes, is student prescribed an inhaler? ☐ Yes ☐ No

Is it self-carry/self-administer? ☐ Yes ☐ No

Diabetes? ☐ Yes ☐ No Insulin dependent? ☐ Yes ☐ No

Seizure Disorder? ☐ Yes ☐ No

If yes, does student have a rescue medication? ☐ Yes ☐ No

If yes, what type? _____

Up-to-date on all school required vaccinations? ☐ Yes ☐ No ☐ Other

If no or other, please explain:

_____

Parent/guardian authorizes the following medication(s) be administered during school hours by an authorized staff member *(only check those for which you authorize use)*:

☐ OTC Pain Reliever ☐ TUMS (antacid) ☐ Benadryl (for allergic reactions only)
☐ Anti-Itch Cream ☐ Cough Drops

Name of Primary Care Physician (PCP): _____

PCP Phone: _____

Date of Last Physical: _____

If your child is currently taking medications, please list them here (for all prescription medication given at school, a doctor's order is required). Please retain a copy or have your child's PCP office fax the doctor's order to 401-216-8091.

NAME OF PRESCRIPTION MEDICATION	DOSAGE & FREQUENCY	TO BE GIVEN AT SCHOOL?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

**** NO MEDICATION WILL BE GIVEN WITHOUT WRITTEN CONSENT ON FILE ****

Any other pertinent medical information OSA should be aware of? _____

_____

_____

_____ _____

Parent/Guardian Signature **Date**