MEDICAL CONSENT FORM

School Year 2025-2026

Student Name: _____ **DOB:** _____

Allergies? □ Yes □ No

If yes what type of reaction: _____

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, known triggers? _____

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

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

Diabetes? □ Yes □ No Insulin dependent? □ Yes □ No

*Please attach updated DMMP + 3 days minimum supply

Seizure Disorder? □ Yes □ No

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

If yes, circle one: Active/Absent: *Please provide updated SAP

If yes, what type? _____

Is the student up to date on all school required immunizations? □ Yes □ No

*Please attach updated physical/immunization record

If No please explain:

_____

PCP Name: _____ **Phone:** _____

Date of Last Physical: _____

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
□ Anti-Itch Cream
□ Sunscreen
□ TUMS (antacid)
□ Cough Drops
□ Benadryl (for allergic reactions only)
□ Eye Drops

If your child is currently taking medications, please list them here:

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

****NO MEDICATION WILL BE GIVEN AT SCHOOL WITHOUT A DOCTOR'S ORDER ON FILE. IT CAN BE FAXED TO OUR SCHOOL @ 401.216.8091****

Any Health Conditions:

□Ear Infections

□Nose Bleeds

□Headaches

□GI conditions

□Eczema

If yes known triggers: _____

Assistive Devices:

□ Glasses

□ Hearing Aids

Any other pertinent medical information OSA should be aware of?

_____

_____

_____

_____

_____

_____ _____

Parent/Guardian Signature **Date**