Massachusetts Academy of Math and Science
Consent for Administration of Approved OTC Medications

Date:___________________________

Student Name: ____

Year of Graduation: ______________________

Is your child allergic or sensitive to any medications? If yes, which ones?______________________________________
____
____

Any medical or health problems? **No** **Yes - Please explain:**

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____
____

List any long-term medication your child receives:____
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____
____

I give permission for my student to receive the medication(s) listed/checked below as deemed necessary by the School Nurse. I understand that a generic equivalent medication may be used. I understand that ***Only the School Nurse***, in accordance with established written protocols, will administer the medication(s) I have checked. Please contact the School Nurse with any questions or concerns.

Ibuprofen
Acetaminophen
Benadryl
Bacitracin
Calamine Lotion
Antacids Tablets
Throat Lozenges

____ ____________________
Signature of Parent/Guardian *Date*

____ ____
Home Phone *Cell Phone*

____ ____
Work Phone *Emergency Phone*