



Hilltown Cooperative Charter Public School

HEALTH CARE CONSENT FORM 2009-2010

Administration of Medications Provided by HCCPS

Student _____ Age _____ Birth Date _____

Current Medications/Supplements _____

Allergies (Food/Drugs/Other) _____

Please indicate which you would like the school to administer to your child:

Yes / No	Ibuprofen (Advil)	Yes / No	Vaseline
Yes / No	Acetaminophen (Tylenol)	Yes / No	Aloe Vera Gel
Yes / No	Bacitracin Ointment	Yes / No	Cough Drops
Yes / No	Caladryl Lotion	Yes / No	Sunscreen
Yes / No	Antiseptic Wound Wash	Yes / No	Antacid (Tums)
Yes / No	Saline Eye Drops		

Yes / No I give the school permission to administer the medications/items indicated at school.

Yes / No I give permission for my child to self-administer inhalers or epi-pens if the school nurse and Health Care Provider (HCP) determine it is safe and appropriate.

Yes / No I give the school nurse permission to discuss my child's health with her/his HCP.

Yes / No I give the school nurse permission to share information relevant to my child's health with appropriate school personnel to insure her/his health and safety.

Yes / No I understand that medications, including vitamins, over-the-counter medications, herbal and homeopathic remedies, **may not be kept by the student**; they must be left with the school nurse or administrator the original container.

I understand that ibuprofen and acetaminophen will be dispensed only when a nurse is present.

I understand that if I do not follow these guidelines, the school staff will not be able to dispense medications/supplements to my child



Name of Parent/Guardian (please print)

Signature

Date