



Granite State Academy

a public chartered high school

Consent for the Administration of Approved Discretionary Medications

Name _____ Date of Birth _____ Grade _____

Allergies/Sensitivities _____

Current Medications _____

I give the School permission to administer the following medications for the temporary relief of discomfort associated with a cold, headache, dental discomfort, muscular aches, pre-menstrual pain, fever, sore throat, upset stomach, allergic reaction, rashes due to poison ivy, oak or sumac, coughs, cuts and scrapes.

Please check any medication you wish to be made available to your child:

Acetaminophen (Tylenol)

Ibuprofen (Advil)

Ointment (Bacitracin)

Anti-itching lotion (Calamine)

Chewable antacid tablets (Tums)

I hereby give my permission for _____ to receive any medications listed above as deemed necessary by the school administration. I understand the generic equivalent of medications may be used in place of more expensive brand name items. I understand that only these medications will be administered. If additional medications are needed, my child will need a separate order signed by his/her doctor.

I do not want any medications given to my child in school.

Signature of Parent/Guardian _____ Date _____

Home Phone Number _____ Work Number _____

Physician's Name _____ Phone Number _____

Dentist's Name _____ Phone Number _____