BAIS YAAKOV SCHOOL FOR GIRLS
RABBI BENJAMIN STEINBERG MIDDLE SCHOOL 443.548.7700 X 2 BYMSOFFICE@BAISYAAKOV.NET

Consent for Administration of Over the Counter Medications Year 2024-2025

Student Name: _____ Date of Birth: _____ Age: ____ **WEIGHT:** _____ Grade: _____

The following medications are stocked in the health suite should your daughter experience minor discomfort or injury that is not resolved from basic comfort measures. All medications will be administered per recommendations delineated on bottle label unless noted otherwise.

Please make an x below over the box of medication you DO NOT want your daughter to receive. Please comment in the section below in more detail if you do not want your daughter receiving specific medications.

Over the Counter Medications:

Acetaminophen (Tylenol) *(for headache/fever/muscle aches/pain/cramps)* 160 mg/5 ml liquid, 160 mg chewable tab, 325 mg tab	**Diphenhydramine (Benadryl)** *(for allergic reactions)* 12.5 mg/5 ml liquid, 12.5 mg chewable tab, 25 mg tab
Ibuprofen (Advil) *(for headache/fever/muscle aches/pain/cramps)* 100 mg/5 ml liquid, 200 mg tab	**Throat Lozenge** *(for cough/sore throat)*
Antacid (Tums) *(for indigestion/heartburn/upset stomach)* 500 mg chewable tab	**Antibiotic Ointment** *(for minor cuts/scrapes)*
Hydrocortisone 1% cream *(for itching associated with minor skin irritation, inflammation and rashes)*	**Sunscreen** *(for sun protection)*

Medication History:

Does your child have allergies to any medications? Y/N

If yes, please state which medications and symptoms: _____

Please list any medications or treatments your child takes at home (dosage, time, and purpose). (Please note that by signing this form it will be assumed that there are no contraindications for your child to be given any of the above listed medications while taking her current home medications).

_____

Please indicate anything else you would like us to be aware of or any special individual medication instructions:

I give permission to the Health Suite personnel to administer the above medications to my child as needed unless indicated otherwise.

_____

Signature of Parent/Guardian **Date**

_____

Signature of Provider **Printed Name of Provider** **Date**

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