



PHILADELPHIA

E&T

CHARTER HIGH SCHOOL

1420-22 Chestnut Street · Philadelphia, PA 19102 · www.petchs.org · Phone: 267-514-1823 · Fax: 267-514-1834

Consent for Administration of Approved Discretionary Medications

Student Name _____

Date of Birth _____ Grade _____

Medication Allergies/Sensitivities _____

List any long-term medication your child receives

I give permission for my child _____ to receive any

Medication checked below on this form as deemed necessary by the registered nurse. I understand generic equivalents may be used and this permission will be in effect for the 2019-2020 school years.

Please check all medications your child can receive at school:

___ Acetaminophen (Tylenol)

___ Ibuprofen (Motrin)

___ Diphenhydramine (Benadryl)

___ Chewable Antacid tablets (TUMS)

___ Topical Medications (Neosporin)

___ Throat Lozenge/Cough Drops

I understand that the above medications I have checked will be administered by the school nurse in accordance with established protocols developed by the school physician and the school nurse.

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

Signature of parent/guardian

Date

Home Phone _____ Work/Emergency Phone: _____

Email: _____