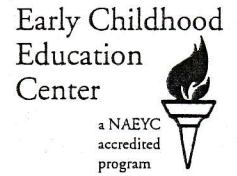


ASSOCIATED  
STUDENTS  
INC, SFSU



## Consent for Medication

Child's Name: \_\_\_\_\_

I give permission for a Head Teacher, Program Coordinator, or Director to administer **ONLY** prescription medication to my child in accordance with directions for use on the prescription's original container.

I give permission for the Head Teacher, Program Coordinator, or Director to administer any of the medications checked below. I will supply the diaper rash cream and/or teething gel in the original container, and I will clearly label them with my child's full name. The Center will keep Infant/Children's Tylenol, Motrin, and Benadryl locked in a medicine box at the front desk. A doctor's prescription is required for all other over-the-counter medications.

\_\_\_\_\_ Diaper rash cream (Desitine, Vaseline, etc.)

\_\_\_\_\_ Teething Gel/Tablets

\_\_\_\_\_ Tylenol/Motrin

\_\_\_\_\_ Benadryl

Note: You will be contacted to pick up your child immediately and **only one dose** of Tylenol or Motrin will be administered to your child on any given day and **only** if your child has a fever. Your child may not return to the Center until 24 hours after s/he has stopped running a fever. **Tylenol or Motrin will not be given for teething.**

You will be contacted to pick up your child immediately and **only one dose** of Benadryl will be administered to your child on any given day, and **only** if your child is showing signs of having a severe allergic reaction in which your child is unable to participate in the program. Your child may not return to the Center until s/he has stopped displaying signs of having an allergic reaction.

Center staff will require that your child be seen by a pediatrician to diagnose the allergy and provide the Center with the necessary written instructions and medication should your child experience the same symptoms in the future.

Parent: \_\_\_\_\_

Signature

Date: \_\_\_\_\_