# Permission to Give Antihistamine Medication at School

Child's Name _____ DOB _____

Medication Benadryl (Diphenhydramine) (Zyrtec) Cetirizine _____

Dosage 25 mg 50 mg 5 mg 10mg Route Orally

To be given at the following time(s) Once a day Every 4-6 hours As needed for symptoms

Special Instructions _____

Purpose of medication Antihistamine _____

Side effects that need to be reported Sedation _____

Starting date _____ Ending Date None

Health Care Provider Name _____ Phone _____

Fax _____

Health Care Provider Signature _____

I authorize this medication to be given to my child as directed above. I give my consent for the nurse to communicate with the health care provider regarding this medication.

Parent Signature _____ Date _____