

Jonesville Community Schools

Jonesville Middle School
401 E. Chicago St.
Jonesville, MI 49250

AUTHORIZATION FOR TREATMENT AND OVER-THE-COUNTER MEDICATION USE

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO RECEIVE FIRST AID OR USE OVER THE COUNTER MEDICATIONS IN SCHOOL. **PLEASE FILL IN ALL AREAS INCLUDING HEALTH UPDATE ON BACK.**

Name of Student

Date of Birth

Address

Telephone

Parent(s)/Guardian Name(s)

Teacher's Name

1. I authorize for my child named above to: **(CHECK ONE OR BOTH)**
 Receive first aid Receive medication at school
2. I will notify the school immediately if there is any change in my child's health status that would affect the use of medication.
3. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or in-directly from this authorization.

The school nurse will apply triple antibiotic ointment, hydrocortisone cream, calamine lotion, and Burn-Jel as needed for rashes, cuts, minor burns and skin abrasions. Cough drops will be given for minor sore throats without fever.

PLEASE CHECK EACH BOX indicating medication(s) your child may receive.

Acetaminophen (Tylenol) Ibuprofen (Motrin/Advil)

Diphenhydramine (Benadryl) - for mild allergic reactions

I wish to be contacted prior to my child being given any medication.

Signature of Parent(s)/Guardian

Date

	Work Phone	Cell Phone	E-mail
Mother			
Father			
Step-mother			
Step-father			
Other			

Preferred method of contact (work, cell, e-mail, etc.) _____

Who to call if my child needs to go home during school hours and **we are unable to reach the parents.**

Name

Phone

Relationship

Name

Phone

Relationship