Jonesville Community Schools
Jonesville Middle School
CONSENT 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.**

STUDENT	BIRTHDATE
ADDRESS	HOME TELEPHONE
PARENT(S)/GUARDIAN(S)	TEACHER

1. I authorize for my child named above to receive any necessary first aid.
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 indirectly from this authorization.

The school nurse or staff under direction of the nurse will apply petroleum jelly, calamine lotion, hydrocortisone cream, and burn jel as needed for rashes, cuts, minor burns and skin abrasions. Ora-Jel will be applied for minor mouth sores/pain. Peppermint or TUMS will be provided for stomach aches. 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)

PARENT SIGNATURE	DATE

	WORK PHONE	CELL PHONE	E-MAIL
MOTHER			
FATHER			
STEP-MOTHER			
STEP-FATHER			
OTHER			

Preferred method of contact: ❒Work ❒Cell ❒E-mail ❒Other_____

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

NAME	PHONE	RELATIONSHIP

-over-

Jonesville Community Schools
Health Information Update

NAME	BIRTHDATE	GRADE
HEALTH INSURANCE		
PRIMARY PHYSICIAN	PHONE	
DENTIST	PHONE	

Does student have any of the following (please check all that apply)?

ALLERGIES ❒ YES ❒NO To medication, food, pollen, etc? List:_____
Requires Epi-Pen? ❒ YES ❒NO
Requires emergency treatment? ❒YES ❒NO
❒IHP on file

ASTHMA ❒ YES ❒NO Diagnosed by doctor? ❒YES ❒NO
Does student bring inhaler to school? ❒YES ❒NO
Requires emergency treatment? ❒YES ❒NO
❒IHP on file

BEE STING ALLERGY ❒YES ❒NO Diagnosed by doctor? ❒YES ❒NO
Requires Epi-Pen? ❒YES ❒NO
Reaction: Difficulty breathing ❒YES ❒NO
Hives ❒YES ❒NO
Local swelling ❒YES ❒NO
Requires emergency treatment? ❒YES ❒NO
❒IHP on file

EPILEPSY/SEIZURES ❒YES ❒NO Medication(s):_____
Type of seizure:_____
Date of last seizure:_____
❒IHP on file

HEART CONDITION ❒YES ❒NO Diagnosed by doctor? ❒YES ❒NO
Medication(s):_____
Restrictions? ❒YES ❒NO
Comments:_____
❒IHP on file

MEDICATION(S) taken regularly

MEDICATION	DOSE	PURPOSE

Last vision exam:_____ **Examiner:**_____ **Wears glasses/contacts?** ❒YES ❒NO

Last hearing exam:_____ **Examiner:**_____ **Tubes in ears?** ❒YES ❒NO
❒Right ❒Left

Please list any family changes, special health problems/behaviors, skills, equipment needs, medical treatments or other concerns that you may have regarding your child, including any serious illness, surgeries or injuries in the last 12 months.

****In order to insure that your child is cared for appropriately, the school nurse will share information that might affect your child's safety and well-being with appropriate school personnel****