Jonesville Community Schools

Emily B Williams Elementary School
440 Adrian 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 _____ Home Telephone _____

Parent(s)/Guardian Name(s) Printed _____ Teacher's Name _____

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 in-directly from this authorization.

The school nurse or staff under direction from the nurse will apply petroleum jelly, calamine lotion, hydrocortisone cream and Burn-Jel as needed for rashes, cuts, minor burns and skin abrasions. Ora-Gel 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) - 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 **<u>we are unable to reach the parents</u>.**

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

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Jonesville Community Schools
Health Information Update

Name of student_____ Birth Date_____ 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

Diabetes ❒Yes ❒No Takes insulin? ❒Yes ❒No
Comments_____
❒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)_____
Physical Restrictions? ❒Yes ❒No
Comments_____
❒IHP on file

Medication(s) taken regularly _____dose_____purpose_____

_____dose_____purpose_____

Last vision exam:_____ Examiner_____ Wears glasses? ❒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****

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