



**Harper Creek Community Schools**  
**Consent for treatment and OTC Medications By School Nurse**



**Student Name** \_\_\_\_\_ **Birthday** \_\_\_\_/\_\_\_\_/\_\_\_\_

I give my permission for my child to receive health education, basic health care treatment, and emergency care from the health aid or the school nurse. In addition, the *school nurse*, when available, may administer any of the following Over-the-counter medications listed below under established protocols as indicated per package instructions and dosage for age/weight.

- |  |  |
|--|--|
| ■ Oral Acetaminophen (Tylenol)           | ■ Oral Ibuprofen (Advil)                             |
| ■ Antihistamine Topical (Benadryl cream) | ■ Oral Antihistamine (Benadryl)                      |
| ■ Calamine/Caladryl Lotion               | ■ Oral Loratadine (Claritin)                         |
| ■ Hydrocortisone 1% Cream                | ■ Eucerin Lotion                                     |
| ■ Saline eye drops                       | ■ Silver Sulfadiazine 1% Cream (Silvadene for burns) |
| ■ Antifungal Topical Cream               | ■ Insta Glucose                                      |
| ■ Orajel Topical                         | ■ Calcium Carbonate Chewable Tabs (Tums)             |
| ■ Triple Antibiotic Cream                | ■ Cough Drops/Throat Lozenges                        |

■ I understand that ALL MEDICATIONS to be administered by school staff other than the school nurse, or are self-carried by the student will require a separate **Medication Administration Authorization Form** to be completed by parent **and** Physician before administration. ALL medications must be in the original, properly labeled container and dispensed by a physician/pharmacist, or be in the original over-the-counter packaging.

■ I understand that if my child requires frequent medication while at school from the school nurse, I will need to provide a completed **Medication Administration Authorization Form** and provide the OTC medication to keep at school.

■ I verify that I am authorized to sign consent for the student named on this document.

■ I further consent to the release of information to my child's primary/specialist care provider, and school personnel regarding follow-up care for assessment/treatment provided, coordination of care, or school services.

■ **This authorization and consent must be completed each time your student changes school buildings.**

■ I understand that I may withdraw my consent at any time during the school year by contacting the health office in writing. It is also my responsibility to update the school with any changes regarding this form.

**Parent/Guardian Name (Please Print):** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Mother/Guardian** \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell# \_\_\_\_\_

**Father/Guardian** \_\_\_\_\_

Home# \_\_\_\_\_ Work # \_\_\_\_\_ Cell# \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION- This must be completed with someone other than the parent above**

**Name (Print):** \_\_\_\_\_ **Relationship to student:** \_\_\_\_\_



**Harper Creek Community Schools  
Student Health Information**



**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_  
 School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

**Student Name** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

Does student have health insurance?  Yes  No  
 If not, would you like information on Healthy Kids, MI Child?  Yes  No  
 Does student have a doctor they see regularly?  Yes  No

Doctor's Name and Phone # \_\_\_\_\_ Date of last physical \_\_\_\_\_

**Does student have any of the following: NONE:**

Medication allergies: _____	Emergency Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment _____
Seasonal Allergies: _____	Emergency Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment _____
Food Allergies: _____	Emergency Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Plan and Medication at school <input type="checkbox"/> Yes <input type="checkbox"/> No
Sting Allergies: _____	Emergency Treatment Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Plan and Medication at school <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma: _____ Triggered by: _____	Inhaler <input type="checkbox"/> Yes <input type="checkbox"/> No Nebulizer <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Plan and Medication at school <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes: _____ Desired BS Range: _____	Uses Insulin <input type="checkbox"/> Yes <input type="checkbox"/> No Pump <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Plan and Medication at school <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Seizure Disorder: _____ Last?: _____ Describe Seizure: _____	Medication <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Emergency Plan and Medication at school <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Condition: _____ Describe: _____	Medication <input type="checkbox"/> Yes <input type="checkbox"/> No _____	Restrictions <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____

List any serious illnesses, surgeries, or concussions: \_\_\_\_\_

**Eyes**  Glasses  Contact Lenses  Other \_\_\_\_\_

**Ears**  Tubes  Frequent Infections  Hearing Aides  Difficulty Hearing (Explain) \_\_\_\_\_

**Other** (Check all that apply)  ADHD  Birth Defects  Bladder/Bowl Disorder  Blood Pressure Problem

Blood/Bleeding Disorder  Dental Problem  Eating Disorder  Headaches  Menstruation Problems

Mental Health Issues  Nosebleeds  Skin Problems  Sleeping Problems  Special Education

**Describe anything checked above:** \_\_\_\_\_

**What Medications are taken regularly?**

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_ Purpose: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_ Purpose: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time: \_\_\_\_\_ Purpose: \_\_\_\_\_