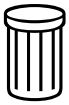

Medications Permission Form

Student's Name: _____ Grade_____ Date_____
Last First

By signing this form I give my permission for any Strickland School staff member to administer the following medications or medical treatments to my child when deemed necessary. The staff member will record the name of the medication, date, time, and the amount given. This form will be kept on file. Medications will be administered according to pre-stated parental directions or according to medication label. We cannot be responsible for medications that the student takes without the knowledge of the teacher or that are self-administered.

Please initial all medications that you will approve in the boxes provided.
First aid for cuts, skin irritations, insect bites and stings:
☐ Alcohol solutions ☐ Antibiotic ointment ☐ Benadryl ointment
First aid for minor pain, headaches or allergies:
☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil or Motrin) ☐ Benadryl ☐ Other_____

Medications that my child takes daily or on a regular basis (inhalers, insulin, etc.):

Name of medication: _____ Dosage: _____

Time Taken: _____ Reason for medication: _____

Allergies to medications: _____

Serious Conditions or Illnesses: _____

Please sign below if the above first aid measures and medications indicated are acceptable. You are giving permission for our staff to administer these medications.

Signature of parent or guardian _____

Printed name_____ Date _____

CONSENT FOR EMERGENCY TREATMENT FOR STUDENTS

I, _____, the parent or guardian of _____, do hereby give my permission to Strickland Christian School, its teachers, administrators and staff to request medical treatment for the above named child in the event of an emergency.

_____ _____
Signature Date

_____ _____ _____
Doctor's Name Address Phone