



## 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  Anti-itch 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.

Doctor's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_