



Medical Permissions/Consent 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 on the lines 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: _____

Reason for medication: _____ Time Taken: _____

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.

X 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.

X _____
Signature _____ Date _____

Doctor's Name _____ Address _____ Phone _____