

BBS Medical Information and Parental Consent Form

Student Name: _____ Grade: _____ School Year: _____

Parents (M) _____ (D) _____

Phone (M) Home: _____ Work: _____ Cell: _____

Phone (D) Home: _____ Work: _____ Cell: _____

Address: _____

Emergency Contact Person: _____ Relationship: _____

Phone Numbers Home: _____ Work: _____ Cell: _____

Pediatrician: _____ Phone: _____

****T C Thompson's Children's Hospital used in emergency unless otherwise indicated. ****

ALLERGIES (Reactions/Treatment): _____

MEDICATIONS taken routinely and why? _____

Consent to give items circled below based on the appropriate dose for the student's age and weight:

Acetaminophen Ibuprofen Benadryl Tums Cough Drops

Topicals: Benadryl/Anti-itch cream Neosporin

Boyd-Buchanan School and its staff have permission to administer First Aid to _____ as necessary. In the event of an emergency and I cannot be reached, I give permission to the staff of Boyd-Buchanan School to obtain whatever care is necessary for the health and well being of my child.

Signature of Parent/Guardian: _____

Health Insurance Plan/Policy Number: _____

If there are any changes in the information completed above at any time, please notify the nurse.

*****Other over-the-counter medications or prescription medications that are needed during school hours must be documents as such by the child's physician and a Medication Card must be completed before being administered. Please see school nurse for this card. *****