Medication/Health Alerts

HEALTH ALERTS – Is your child being treated for any of the following? (please check)
Allergy Bee Sting _________ *EpiPen______
Asthma ______ *Inhaler?_________
Allergy: Food ______ Dairy_____ Other__________
Nuts ____*Type of Nut: Peanut____Tree____ *EpiPen______
Allergy: Seasonal_______________________
Depression ______ Anxiety______
Diabetes ______ *Insulin?_______
Allergy Medication: Penicillin _____ Sulfa_____
Other ___________________________________
*Epilepsy _______________
Blood Pressure High _____ Low _____
Hypoglycemia __________
Migraine ____________
ADD ________ ADHD____________
*Other____

Permission Form for Medication

School_______________________________
Date form Received ________________
Student Name________________________________
Date of Birth_________________________
Grade_______________
Teacher_____________________________

If you checked any of the above aliments/conditions, is your child given medication for the condition? YES_____ NO_____
DOES YOUR CHILD HAVE A CHRONIC CONDITION WE NEED TO KNOW ABOUT? YES___ NO___ *Is there a Medical Plan for this condition? YES ___ NO___ *If YES, CONTACT THE OFFICE TO MEET WITH THE PRINCIPAL IF *HEALTH ALERT* IS LIFE THREATENING. THANK YOU!

Permission for School Staff to Administer Prescription/OTC Medication to Minor Student

ALL MEDICATION (INCLUDING OVER THE COUNTER) MUST BE KEPT IN THE ELEMENTARY OFFICE.

I recognize that while my son/daughter is attending Webberville Community Schools medical treatment on an emergency basis may be necessary and that school personnel may not be able to reach me for my consent for emergency medical care; **I hereby consent to emergency medical care, including hospital care, as may be necessary under the existing circumstances.**

Parent/Guardian Signature ____ Date_________________________

***Name of Medication*____**

***Reason for medication (optional)* ____**

***Prescribing Physician:*____**

Form of Medication/Treatment: Tablet/Capsule Inhaler Injection Nebulizer Other (please circle)

Instructions:

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***Start Date:*______________________ *Stop Date:*___________________________**

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I request that my child (name)*_______________________________*receive the above medication at school according the prescribing doctor's instructions.

***Date*_____________ *Signature*_______________________________ *Relationship*_____________**

Medication (including Tylenol, Motrin, Sudafed, Advil, Allergy/Cough Syrup, TUMS) MUST in the original container with child's name/information on the bottle. (Baggies of loose medication will NOT be accepted) *Medication(s) need to be delivered/picked up by the Parent/Guardian ONLY.