

**Community School Nursing Program
Consent for Treatment**



Student Name _____ **Birthdate** ____/____/____

I give my permission for my child to receive health screenings, BMI measurement/data collection, and health education, basic health care treatment, and emergency care. In addition, the school nurse may administer any of the medications listed below in accordance with established protocols .

- | | |
|---------------------------------------|---|
| ▪ OTC Antibiotic Ointment | ▪ Chewable Antacid Tablets (Tums) age appropriate |
| ▪ OTC Antihistamine Cream | ▪ Caladryl/Calamine Lotion |
| ▪ Anti-Fungal Topical Cream | ▪ OTC Hydrocortisone 1% Cream |
| ▪ Eucerin Lotion (for Dry Skin) | ▪ Silver Sulfadiazine 1% Cream (Silvadene for burns) |
| ▪ Acetaminophen (Tylenol) | ▪ OTC Oral Diphenhydramine HCL (Benadryl for allergic reaction) |
| ▪ Ibuprofen (Advil) | ▪ Sterile Wash for Skin & Eyes |
| ▪ OTC Oral Loratadine (Antihistamine) | ▪ Saline Eye Drops (Non-medicated) |
| ▪ Cough Drops/Throat Lozenges | ▪ Insta Glucose |
| ▪ Orajel for tooth pain | |

- I understand that All Medications to be administered by school staff or are self-carried by the student require the **Medication Administration Authorization Form** to be completed by the Parent & Physician prior to administration. ALL medications must be in the original, properly labeled container & dispensed by a physician/pharmacist, or be in the original over the counter packaging.
- I verify that I am authorized to sign consent for the person named in this document.
- I further consent to release of information to my child’s primary/specialist care provider, and school personnel regarding follow-up care for assessment/treatment provided, coordination of care or school services.
- **This Consent will be in effect from the date signed until the student changes school buildings.**
- I understand that I may withdraw my consent at any time during the school year by contacting the health office in writing.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ **Date:** _____

Mother/Guardian _____

Home # _____ Work # _____ Cell # _____

Father/Guardian _____

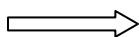
Home # _____ Work # _____ Cell # _____

EMERGENCY CONTACT INFORMATION – This must be completed with someone other than parent above.

Name (print): _____ **Relationship to Child:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

*** THIS CONSENT WILL BE IN EFFECT UNTIL THE STUDENT CHANGES SCHOOL BUILDINGS ***



OVER (COMPLETE BOTH PAGES OF THIS FORM)

