AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parents or Guardians:

The following information is necessary for any student to use prescribed medications or to receive treatment in school. All spaces must be completed.

_____ _____

Name of Student Address

_____ _____

School Grade

A. I am requesting permission for my child named above to: (check all that apply)

_____ use or receive prescribed medication

_____ received prescribed treatment

_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

AUTHORIZATION FOR ADMINISTERING ACETAMINOPHEN (TYLENOL)

I give the MS/HS office permission to dispense Acetaminophen (Tylenol) to my student _____ . Please indicate below the dosage and the circumstances in which it may be dispensed.

Dosage_____

Circumstances_____

Parent/Guardian Signature_____ Date_____

GRADE_____

NORTH MUSKEGON MIDDLE/HIGH SCHOOL
2014-2015 Family Contact/Emergency Medical Care Form

Student Name: _____
(Last) (First) (Middle)

Address: _____
(Street Address) (City) (State) (Zip)

Home Phone: _____ Date of Birth: _____ Gender: Male Female

Is any information above different from the previous school year? Yes No

Who is the primary contact for your child? Mother Father
Other: _____

	Mother	Father
Name:		
Address:		
Employer:		
Work Phone:		
Cell Phone:		
School Alert/Phone #:		
Email:		

	Stepmother	Stepfather
Name:		
Address:		
Employer:		
Work Phone:		
Cell Phone:		
School Alert/Phone #:		
Email:		

Emergency Contacts:

	First	Second	Third
Name:			
Relationship:			
Phone:			
Cell Phone:			

Family Doctor:_____ _____

Please check any of the following conditions that may apply to your child. Explain in as much detail as you can, below if necessary.

- ☐ Allergies to medications
- ☐ Allergies (seasonal)
- ☐ Allergy to bee sting
- ☐ Asthma
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Easily Upset stomach
- ☐ Epilepsy
- ☐ Fainting
- ☐ Orthopedic limitations
- ☐ Vision problems
- ☐ Wears corrective lenses (glasses)
- ☐ Hearing problems
- ☐ Other: (Please explain)

_____