Medical Treatment Authorization

Student: ______________________________ DOB: __________ Grade: _____

Parent/Guardian: ______________________________ Phone: ______________

Primary Doctor: ______________________________ Phone: ______________

Drug/Food Allergies: ______________________________

Health History/Medical Concerns: Please give a ***detailed explanation*** of your students past and present medical diagnoses and/or health concerns that you would like the school nurse to be aware of:

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Current Medications: Please list, including reason for taking:

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I give permission for the school staff or St. Alphonsus Nursing team to provide the following over the counter medications to my child if needed. Please check YES or NO for each medication.	**YES**	**NO**
Tylenol		
Ibuprofen		
Benadryl		
Hydrocortisone Cream 1%		
Bacitracin or other anti-infective ointment		
Benadryl cream for itching		
Cough Drops		
Tums or Calcium Carbonate		
Saline eye drops		
Aquaphor ointment		

Special Instructions: Please list any specific instructions regarding your child's health that you would like the school nurse to be aware of:

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In the event of an emergency or non-emergency situation requiring medical treatment of my student while on the school campus, I, the undersigned parent/guardian, give the school staff and Saint Alphonsus Nursing team my consent and authorization to provide medical treatment that is deemed necessary.

Parent/Guardian Signature: ______________________________ Date: ______________

Saint Alphonsus School Health Staff