PARENTAL/GUARDIAN CONSENT FOR MEDICAL TREATMENT
Boone Central Schools 2023/2024

General Information	
Last Name:	First Name:
Date of Birth:	Grade:
Parent/Guardian Name:	Phone:
Parent/Guardian Name:	Phone:

Health Information

Primary Healthcare Provider:

Primary Dentist:

Current Medications:

Check which apply:

{ }ADD/ADHD	{ }Allergy(s):_____	{ }Asthma
{ }Anxiety/Depression/Mental Health	{ }Developmental Delays	{ }Diabetes
{ }Food Intolerance/Lactose/Celiac	{ }Headaches/Migraines/Post Concussion	{ }Seizures
{ }Hearing/Vision Impairment	{ }Heart Condition	{ }IBS/Incontinence

Other/Comments:_____

{ }Will need emergency medication kept at school
{ }Will need medication during the school day

Medication Administration

Please allow my child to receive the following medications as deemed necessary by the school nurse or other trained professional of Boone Central Schools. I give consent for the following medications without subjection to liability from illness or injury. It is the parent/guardian's responsibility to let the school know if a dose has already been given prior to school.

___ Yes___ No	Acetaminophen/Tylenol
___ Yes___ No	Ibuprofen/Motrin
___ Yes___ No	Cough Drops
___ Yes___ No	Antacid Tablet/Tums
___ Yes___ No	Saline Eye Drops (itchy eyes/contacts)
___ Yes___ No	Orajel (cold sores/tooth pain)
___ Yes___ No	Saline Nasal Spray/Afrin (nosebleeds)
___ Yes___ No	Topical Creams (antibiotic/burn/itch)

I consent for the release of the information contained in this document to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. As a parent/guardian I also authorize Boone Central School staff to obtain and to administer emergency medical treatment by professional medical personnel to my child at school, or on authorized school transportation, or on a school-endorsed activity without subjection to liability.

_____ _____

Parent/Guardian Signature Date