

PARENTAL/GUARDIAN CONSENT FOR MEDICAL TREATMENT
Boone Central Schools

General Information	
Student Last Name:	Student 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 subsection 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. (please circle Yes or No)		
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 subsection to liability.

Parent/Guardian Signature

Date