MACON COUNTY ELEMENTARY SCHOOL
Consent For Medical Treatment

Student:_____Teacher_____Grade_____

___YES, I give permission for my child to see the nurse or school staff for any health problems or complaints that may arise at school.

___**NO**, I do not give permission for my child to see the nurse or school staff for any health problems or complaints that may arise at school. I am aware that the school will contact me and I will be responsible for providing my childôs care.

If needed, I am authorizing the school to give: (please check)

___Tylenol / Ibuprofen (liquid or regular strength tablets) for headache, fever or pain.
___Mylanta / Tums (stomach ache)
___First Aid ï Peroxide / Neosporin / Bandaids (cuts and scrapes)
___Saline Eye Drops (irrigation)
___Orajel (toothache, mouth sores)
___Benadryl cream / Liquid / Hydrocortisone cream (itching, bug bites, skin irritations)
___Cough Drops (sore throat, cough)

*****Reminders:**

- Children needing any of the above medication on a regular basis will need to provide the school with the medicine in original bottle labeled with studentôs name and must be accompanied with a completed ñAuthorization To Give Medicineò form. Please DO NOT send medicine to school with child, parents must bring all medicine to the clinic.
- A note will be sent home with students that are seen in clinic on frequent basis (3 times in one week) accompanied by a phone call to discuss any concerns or needs that need to be addressed.

Parent/Guardian Signature:_____

Date:_____