STUDENT NAME_____GRADE_____

HAMPTON-DUMONT COMMUNITY SCHOOL

GRADES 9 through 12

MEDICATION PERMISSION

The staff has my permission to administer the following medications . (Please check which medications your son/daughter may receive for minor health problems, i.e. headache, cold, sore throat, earache, or menstrual cramps.)

Acetaminophen (Tylenol) 325mg.____ 1 tab___ 2 tabs every 4-6 hrs. as needed

____Antacids (TUMS) 1 or 2 daily as needed for stomach upset

____DO NOT GIVE ANY MEDICATIONS

_____ _____

PARENT SIGNATURE DATE

HEALTH PERMISSION

I give my permission for pertinent health information to be shared with staff involved with my child's education.

_____ _____

PARENT INITIALS DATE

EMERGENCY CARE

In case of accident or serious illness, I request school staff contact my emergency designee or me. If unable to reach my emergency designee or me I hereby authorize school staff to call the local clinic or hospital and to follow their instructions. I understand that expenses incurred for emergency treatment will be my responsibility. ***I understand it is my responsibility to keep emergency contact numbers update throughout the school year***

_____ _____

PARENT INITIALS DATE