UNIVERSITY OF DETROIT JESUIT
HIGH SCHOOL AND ACADEMY

Consent to Treat & Over-the-Counter Medication Form

University of Detroit Jesuit High School and Academy recognizes its responsibility to its students, especially in times of an emergency. The school retains a health professional who is available for the care of students during school hours in the case of unexpected, non-chronic illness or injury. In order to adequately care for students, the following consent is required.

We/I consent for the School Health Professional of University of Detroit Jesuit High School and Academy to treat our/my son_____(name) if deemed necessary or advisable based on his presentation to the Student Affairs Office. In the event that immediate medical attention of a true emergent nature is necessary, and one or both parents or a legal guardian cannot be immediately contacted, authorities of University of Detroit Jesuit High School are authorized to proceed with contacting emergency services and seeking emergency care as deemed appropriate.

It is recognized that minor symptoms occur that may not be relieved through comfort care or homeopathic measures. The School Health Professional does have certain over-the-counter medications in stock which can be administered if authorized by the parent on this form.

Before granting school permission to administer over-the-counter medication, please check with your doctor/pharmacist that the medications below do not interact with any medications your son may already be taking.

Student's Last Name First Name DOB Grade

_____ **No**, my son **may not be given** any over-the-counter medications or options listed below. We/I understand that only comfort care measures (such as an ice pack) will be administered until I am contacted.

_____ **Yes**, my son **may** see the School Health Professional and **receive** the over-the-counter medications indicated below if deemed appropriate based on his presentation/symptoms. I have checked with his physician/pharmacist as to verify the safety with his other medication.

___ Acetaminophen (Tylenol) 325mg tablets (1 or 2)
___ Ibuprofen (Motrin/Advil) 200mg tablets (1 or 2)
___ Saline eye rinse &/or nasal spray
___ Benadryl antihistamine (for generalized allergic reaction) 25mg
___ Benadryl or cortisone cream (topical itching/rash)
___ Tums antacid
___ Cough Drops (menthol, i.e. Halls)

Parents/Guardians will be notified via email if the above checked medication(s) are administered.

Parent/Guardian Signature _____ Date _____

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Permission Form for Prescribed Medication

To be completed by the authorizing prescriber

Student's Name: _____ Date of Birth_____ Grade_____

Name of Medication: _____

Form of Medication: _____Tablet/Capsule _____ Inhaler _____ Injection _____ Other

Is this medication for Emergency events only (i.e. Anaphylaxis): _____ Yes _____ No

Dose to be given: _____

Frequency to be given/Directions: _____

Restrictions &/or Important Side effects: _____

_____ None

Check here_____ if this release is for a metered dose asthma inhaler, which the student will possess and use at his own discretion in school or at school activities (as permitted in Public Act 10-Revised School Code)

Physician's Signature: _____ Date: _____

Printed Name: _____ Phone number: _____

To be completed by Parent/Guardian

I request, as legal guardian, that my son/ward _____be administered the above prescription medication at school. I understand it is my responsibility to provide the medication in its original container and to notify the school of any change or discontinuation of the medication. I hereby waive any liability whatsoever against University of Detroit Jesuit High School or any of its personnel/agents that which might occur in relation to the dispensing of the said medication in the dosage and frequency as prescribed above to my son/ward.

Print Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

Relationship: _____

Date: _____