



# UNIVERSITY OF DETROIT JESUIT

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## 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.

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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.

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Student's Last Name	First Name	DOB	Grade
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\_\_\_\_ **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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