

**INDIAN CREEK SCHOOL  
EMERGENCY PROCEDURES AND OVER-THE-COUNTER MEDICATIONS PERMISSION  
2009-2010**

By signing "Permission for Medical Treatment", I authorize the school nurse, or her designate, to communicate with the student's physician, if necessary, and to forward pertinent health information to the faculty and athletic personnel with the intention of facilitating a supportive school environment for the student. This communication may be in oral or written format, including direct person-to-person, e-mail and facsimile. This authorization shall become effective immediately and shall remain in effect for one year from the date of signature. I understand I may revoke this authorization at any time. My revocation must be in writing, show the effective date of revocation, signed by me or on my behalf, and delivered to the school nurse.

All health information is considered confidential and will be handled with due discretion. This form may accompany the student for off-campus events.

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Entering Grade \_\_\_\_\_

Home Address: \_\_\_\_\_

Parent/Guardian

Parent/Guardian

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

Emergency Contact Other Than Parent/Guardian

Name: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Student's Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Permission for Medical Treatment/Transportation

In the event that parents/legal guardians named on this form cannot be contacted, I authorize officials of Indian Creek School to consent, on my behalf, to emergency treatment for my child named above. In emergencies requiring immediate medical attention, my child may be taken to the nearest hospital emergency room. I authorize Indian Creek School personnel to have my child transported and treated at that hospital.

I agree to assume financial responsibility for all expenses associated with the emergency care and/or transportation of my child. Additionally, I agree to indemnify and hold harmless Indian Creek School, its officers or employees, for any injury or loss related to medical treatment my child may receive.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Parent/Guardian Name: \_\_\_\_\_

Permission for Over-the-Counter Medications

\_\_\_\_\_ I DO NOT WISH MY CHILD TO RECEIVE ANY OVER-THE-COUNTER MEDICATIONS.

I authorize the school nurse, her designate or coaches or athletic trainers to administer the following medications at their discretion (please check all that apply):

\_\_\_\_\_ Acetaminophen (Tylenol)/Middle School/Upper School—  
500 mg every 4 hours for student complaints of pain,  
headache, cramps, earache, or fever above 100.6

\_\_\_\_\_ Acetaminophen (Tylenol Junior Strength)/Lower  
School—320/480 mg every 4 hours for student  
complaints of pain, headache, cramps, earache,  
or fever above 100.6

\_\_\_\_\_ Ibuprofen (Advil)— 200 mg every 4 to 6 hours for  
student complaints of pain, headache, cramps,  
earache or fever above 100.6

\_\_\_\_\_ Benadryl —1 to 2 tsps every 4 to 6 hours for student  
complaints of symptoms of allergic reactions  
including hives, itching and swelling

\_\_\_\_\_ Tums Antacid—Regular Strength—500 mg for student  
complaints of indigestion

\_\_\_\_\_ Saline for eye irritation/contact lenses

\_\_\_\_\_ Neosporin topical antibiotic cream for student complaints  
of cuts/scrapes

\_\_\_\_\_ Cough drops for student complaints of sore throat/  
excessive coughing

(Please note: For PK through 3rd grades, parents will be notified before any medication is given.)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_