CLOVERDALE COMMUNITY SCHOOL CORPORATION

Medical information about your child may be shared with administrators, teachers, staff, and bus drivers. Please provide written notifications to the nursing staff if you prefer the medical information not be shared with school personnel.

STUDENT:_____ DOB:_____ GRADE:_____

PARENT/GUARDIAN:_____

PHONE (H):_____ (W):_____ (M):_____

EMAIL ADDRESS:_____

HEALTH CARE PROVIDER:_____

In case of emergency, whom would you like us to contact, if you can not be reached:

NAME:_____ PHONE:_____ RELATIONSHIP:_____

NAME:_____ PHONE:_____ RELATIONSHIP:_____

Does your child have any allergies to medications, food, or latex? If yes, please list and explain:

_____

Please list any health concerns. Do these health concerns require any special considerations?

_____

Is your child on any medications? If yes, please list the name, dose, frequency, and purpose:

_____

_____

Whenever my student is involved in a school activity and I am unavailable or otherwise unable to provide the authorization directly, I grant to the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnoses, and treatment, including surgical intervention, if necessary, on behalf of my minor child and to do all other necessary things as I might or could do to provide for the child's health and safety, if I were present. This authorization is valid for the current school year or until such time as I withdraw the authorization.

Parent/Guardian Signature:_____ Date:_____

CLOVERDALE COMMUNITY SCHOOL CORPORATION

Student Name:_____School Year:_____

I hereby give permission for the Cloverdale School staff members to administer to my dependent, the above-named student, during school hours in accordance with the instructions provided on the bottle, instructions provided directly to the school corporation by the child's health care provider, and/or emergency care of injuries and illnesses occurring at school in accordance with guidelines established by the Indiana State Department of Education with respect to the following medications:

CHECK ALL THAT ARE OKAY TO GIVE

- ☐ **Acetaminophen(Tylenol)** for headaches, cramps, pain, or as otherwise directed by a healthcare provider
- ☐ **Ibuprofen (Advil/Motrin)** for headaches, cramps, pain, or as otherwise directed by a healthcare provider
- ☐ **Antacid Tablets (Tums)** for upset stomach or as otherwise directed by a healthcare provider
- ☐ **Antibiotic Ointment (Bacitracin)** for cuts, scrapes, or as otherwise directed by a healthcare provider
- ☐ **Anti-itch ointment/cream/lotion** for itching, or as otherwise directed by a healthcare provider
- ☐ **Cough drops** for coughs and sore throats.
- ☐ **Diphenhydramine (Benadryl)** for allergic reactions or as otherwise directed by a healthcare provider
- ☐ **Sterile Eye Drops** for eye irritation or as otherwise directed by a healthcare provider

I understand that it is my legal obligation to provide immediate written modification to the Cloverdale School nurse should any changes to this form be deemed necessary as the school year progresses.

I also understand that by signing this form I have voluntarily sought the assistance of representatives of the Cloverdale Community School Corporation to oversee the administration of the above-checked substances. As a result, I understand that I have no right to make a claim or file a lawsuit against the Cloverdale Community School Corporation, its Board of Trustees, employees, administrators, agents, insurers, or any other person or entity that results in damage in connection with, arising out of, or in the course of the administration of the above-checked medications and knowingly and voluntarily waive any such rights.

Parent/Guardian Signature:_____Date:_____