Pioneer Valley Performing Arts Charter Public School

Parent Permission for Over-the-Counter Medication And Parent Consent to Share Information

★ **Student Legal Name** _____/_____

Student First Name *(print clearly)* Student Last Name *(print clearly)*

★ **Emergency Medical Contacts**

1) _____ (_____)_____-_____

Physician Name *(print clearly)* Area Code Phone number

2) _____ (_____)_____-_____

Dentist Name *(print clearly)* Area Code Phone number

★ **Allergies** Please include information about allergies to bee stings, drugs, food, etc.

_____

_____

_____

I give permission for the school nurse (or delegated staff) to administer to my child as needed during school hours. Please check all that apply:

Acetaminaphen (Tylenol) not exceeding 650 mg. in a day _____

Ibuprofen (Advil, Motrin) not exceeding 400 mg. in a day _____

Antihistamine/Diphenhydramine (Benadryl) not exceeding 50 mg. in a day _____

Antacid/calcium carbonate (Tums) not exceeding 4 tables in a day _____

If the school is unable to reach a parent, in the event of a serious accident or illness, I hereby authorize the school to call my child's listed physician and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary.

☐ Yes ☐ No

I give permission for the school nurse to share my child's diagnosis of hearing or vision problems, asthma, allergy, and/or food intolerance with appropriate school personnel as well as information relative to the prescribed treatment for his/her condition.

☐ Yes ☐ No

_____ _____

Parent Signature Date