**Menahga Public School**
**Health Office**
**Medical Emergency Contacts &**
**OTC Med Permission (Grades 6-12)**

**Last Name:** ______________________________

## Emergency Contact Information

Parent/Guardian Name : ______________________________ Home: ____________________
**(Call First)**
Cell: ______________________________ Business: ____________________

Parent/Guardian Name: ______________________________

Cell: ______________________________ Business: ____________________

If my child becomes ill, and I cannot be reached, please call:

1. ______________________________ Phone No. ______________________________

2. ______________________________ Phone No. ______________________________

**Parent/Guardian Signature:** ______________________________ **Date:** ______________

By signing this form, you are giving consent for this information to be shared with school staff who teach, interact or work with your child during the school day.
**Notify the school if your address or telephone number changes.**
The welfare of your child is the first priority of school authorities. In case of a **serious emergency**, the school will contact emergency services, then contact you. In less serious instances, you will be called first. You will be contacted in either event.
It is your responsibility to make arrangements for proper care of your child should he meet with an accident or become too ill to remain in school at a time when you are not home. Please complete this form and promptly return it to the school.

## List all students in the household:

Complete a separate ***Health Update Form*** for any new student or any student with a new health condition. Health Update Forms will be entered into the student health record.

1. Name: ______________________________ DOB: ____________________ Grade: __________
   Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
   If checked, please explain: ______________________________________________

2. Name: ______________________________ DOB: ____________________ Grade: __________
   Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
   If checked, please explain: ______________________________________________

3. Name: ______________________________ DOB: ____________________ Grade: __________
   Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
   If checked, please explain: ______________________________________________

4. Name: ______________________________ DOB: ____________________ Grade: __________
   Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
   If checked, please explain: ______________________________________________

***Continue on reverse***

**Last Name:** ______________________________

5. Name: __________________________________ DOB: _______________________ Grade: __________
   Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
   If checked, please explain: ______________________________________________________________

6. Name: __________________________________ DOB: _______________________ Grade: __________
   Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
   If checked, please explain: ______________________________________________________________

7. Name: __________________________________ DOB: _______________________ Grade: __________
   Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
   If checked, please explain: ______________________________________________________________

8. Name: __________________________________ DOB: _______________________ Grade: __________
   Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
   If checked, please explain: ______________________________________________________________

9. Name: __________________________________ DOB: _______________________ Grade: __________
   Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
   If checked, please explain: ______________________________________________________________

10. Name: __________________________________ DOB: _______________________ Grade: __________
    Check any that apply: ◯ Allergies ◯ Asthma ◯ Medical Condition ◯ Medication at School
    If checked, please explain: ______________________________________________________________

## Students in Grades 6-12 ONLY

Over-the-Counter **Non-Prescription** Medication Permission

I give permission for my child[ren] in grades 6-12: ______________________________________________, to self-administer over-the-counter medication[s] such as acetaminophen, ibuprofen, naproxen, tums, etc… at school. The medication must be used in a manner consistent with labeling instruction and not shared with any other student. **No products containing ephedrine or pseudoephedrine are allowed.** The privilege to self-administer non-prescription medication will be revoked if the student does not follow the above guidelines.

**Students must provide their own medication in the original container**.
**The school does not provide any medication.**

This permission is valid for students in **grades 6-12** for the current school year only.

Please list OTC Medication(s): ______________________________________________________________

**Parent/Guardian Signature:** _________________________________________ **Date:** _______________