Judson Middle School

Tylenol Permission Form

I request that my child be given the following medication at school

Student Name:_____ Grade:___ DOB:_____

Acetaminophen (Tylenol)

As per District Physician's standing orders

To be given for school year_____. A new permission slip MUST be signed at the beginning of each new school year.

Parent Signature_____ Date:_____

Home Phone Number_____ Cell Phone Number_____

JISD EMERGENCY PHYSICIAN AND CARE AUTHORIZATION

LAST NAME FIRST MIDDLE DATE OF BIRTH SEX GRADE

ADDRESS _____ HOME PHONE _____

FATHER'S NAME _____ Work Phone _____ Cell Phone_____

MOTHER'S NAME _____ Work Phone _____ Cell Phone_____

GUARDIAN'S NAME _____ Work Phone _____ Cell Phone_____

If parent/guardian cannot be contacted, please indicate alternate adult(s) whom the school should call:

Alternate Adult	Relationship	Home Phone	Cell Phone
Alternate Adult	Relationship	Home Phone	Cell Phone

Other instructions: _____

I, the undersigned, do hereby authorize officials of Judson ISD to contact directly the persons named on this card, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of the child.

In the event parents, other persons named on this card, or physicians cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of said child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature _____ Date _____

TURN TO OTHER SIDE

Student Health Information Release Form

Parents/Guardians: If your child has a history of allergies, takes medication, wears eyeglasses/contacts or has any health related concerns, it is important to give that information to the school nurse. The Family Education Rights and Privacy Act (FERPA) has issued regulations which require public schools to obtain written consent to disclose medical information. All information will be held in the confidence by the school nurses and will be shared only with other school professionals as necessary. If you have any concerns or question, please do not hesitate to contact the school health office.

Student Name: _____ Date of Birth: _____

Home Phone: _____ Emergency Contact Phone: _____

School: _____ Teacher: _____ Grade: _____

	Check one *(if yes, please specify)*:		
Allergies	☐ Yes	☐ No	*(If an EpiPen injection is necessary, a "permission to dispense" form must be submitted every school year.)*
Asthma	☐ Yes	☐ No	*(If an inhaler is necessary, a "permission to dispense" form must be submitted every school year.)*
Hearing Difficulties	☐ Yes	☐ No	
Vision Difficulties	☐ Yes	☐ No	☐ Eyeglasses ☐ Contact Lenses ☐ Other:
Seizure Disorder	☐ Yes	☐ No	
Orthopedic Difficulties/Walking Aides	☐ Yes	☐ No	
Medications *(list condition and dosage)*	☐ Yes	☐ No	

Other pertinent information (including hospitalizations within the last year):

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

_____ _____ _____

Parent/Guardian Name (please print) Parent/Guardian Signature Date