

L.B. REYNOLDS ELEMENTARY SCHOOL
221 STRONG AVENUE
READING, MICHIGAN 49274

AUTHORIZATION FOR MEDICATION OR TREATMENT FOR MINOR SCHOOL (SICKNESS)

To the Parent or Guardian of:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE OVER THE COUNTER MEDICATION OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ Name of Student	_____ Telephone
_____ Address	_____ Date of Birth
_____ School	_____ Teacher's Name

- I give permission for my child named above to: (Check one or both)
_____ Receive over the counter medication by school personnel when necessary
_____ Receive treatment, (band aides, ointments) by school personnel when necessary
- I will notify the school immediately if there is any change in the use of over the counter medication for my child.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or in-directly from this authorization.

_____ Signature of Parent or Adult Student	_____ Home Telephone	_____ Date
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Mother's Name _____	Mother's Work Telephone _____
Father's Name _____	Father's Work Telephone _____

IF PARENTS CANNOT BE REACHED WHO SHOULD WE CONTACT? (YOU MUST LIST TWO)

- _____
(NAME) (RELATIONSHIP) (TELEPHONE)
- _____
(NAME) (RELATIONSHIP) (TELEPHONE)
- _____
(NAME) (RELATIONSHIP) (TELEPHONE)

PLEASE CHECK MEDICATIONS ON BACK YOUR CHILD MAY RECEIVE

