

**MEDICAL CONSENT**

In the event our child \_\_\_\_\_, becomes ill or sustains an injury while attending Children's Learning Program of Zionsville United Methodist Church in Zionsville, Indiana. I the undersigned give permission to those in charge to administer First Aid. I also consent to an x-ray examination, anesthetic, medical (or dental) or surgical diagnosis and treatment and hospital care, and the administration of drugs or medicine to be rendered to my child under the general or specialized supervision and upon the advice of a duty licensed physician and/or surgeon. I understand that this consent will apply to all emergency situations present and future, and that a copy of this form is valid as the original. This consent is to remain in effect until written revocation is made.

Date \_\_\_\_\_  
Signature of Parent or Legal Guardian \_\_\_\_\_

Address \_\_\_\_\_  
Phone \_\_\_\_\_

Any special health problems:  
Describe \_\_\_\_\_

Any Medications: (Name, Dose, Prescribing Physicians)

Regular Doctor \_\_\_\_\_  
Phone \_\_\_\_\_

**MEDICAL PERMISSION**  
**CHILDREN'S LEARNING PROGRAM**

\_\_\_\_\_  
Student's Name (Please Print)                      Age                      Teacher

A few children experience an allergic reaction to the sting of bees, wasps, hornets, and or food. Since allergic reactions can be serious at times and require prompt treatment, our medical consultant has recommended that the teacher and a designated office staff administer oral Diphenhydramine HCL/Benadryl to children who have been stung or are exhibiting a reaction to food, dye, or juice.

\_\_\_\_\_  
YES Children's Learning Program is here by given permission to administer the medication Diphenhydramine HCL/Benadryl by mouth to my child named above, according to the dosage outlined below, in the event that my child is stung by a bee or wasp at school, or exhibits a reaction to food.

**DOSAGE:** Please circle one    15-25 lbs    1 Tsp    25-35 lbs    1 ½ Tsp    35-45 lbs    2 Tsp  
45-55 lbs    3 Tsp

*\*If parent does not fill in dosage, we cannot administer the medication.*

\_\_\_\_\_  
NO I do not wish my child to be given oral Diphenhydramine HCL/ Benadryl in case of a bee or wasp sting, or a reaction to food. If no, reason:

\_\_\_\_\_.

\_\_\_\_\_  
YES My child has had a severe life-threatening reaction to a bee or wasp sting. Please explain on the back of this form the type and symptoms of this reaction and what needs to be done at school.

\_\_\_\_\_  
Signature of Parent or Guardian    Phone:    (Home)                      (Work)

(OVER)