



PARENTAL CONSENT FOR FIRST AID TOPICAL MEDICATION

THE FOLLOWING FIRST AID MEDICATIONS MAY BE USED IF A STUDENT PRESENTS TO THE CLINIC FOR A SIGNIFICANT CUT, SCRAPE, INSECT BITE, UNSPECIFIED WOUND OR FOREIGN BODY IN EYE.

**Aquaphor healing
ointment**



**Dermoplast
Burn & Itch Spray**



**1% Hydrocortisone
cream Aveeno**



**0.9% saline solution
eye wash**



I, _____ (Print Parent Name)
authorize the nursing and/or administrative staff at BSA to apply the above listed medications to my
child(ren) listed below:

Student Name _____	Grade: _____
Student Name _____	Grade: _____
Student Name _____	Grade: _____
Student Name _____	Grade: _____
Student Name _____	Grade: _____

By signing this document, I acknowledge that: (INITIAL NEXT TO EACH)

- _____ I have done my due diligence as a parent and reviewed the manufacturer labels of the products listed above. My child has no known allergies to any ingredients in these products.
- _____ BSA will not be held liable for any allergic reaction a student may experience to products listed above.
- _____ These medications will be administered according to the manufacturer's recommended use & dosage, and in a first aid capacity only. They will not be administered for chronic skin conditions or prolonged care.
- _____ If I want a different medication given to my student, I am responsible for providing medication to nurse.
- _____ It is my responsibility to update nurse with any change in allergy or health condition for my child.
- _____ My student will only be given these medications if I have submitted legible consent. If no consent is given, my child's wounds can only be treated with water and/or bandages

PARENT SIGNATURE(S): _____

DATE: _____