Student Health & Medication Form

Student name_____ Birth date_____ Grade level_____

Physician _____ Phone (____)_____ Dentist _____ Phone (____) _____

Health conditions. *Please check all that school staff should be aware of.*

- ❑ Asthma. Uses inhaler ❑yes ❑no
  Will inhaler be sent to school? ❑yes ❑no
- ❑ Bone disease/fractures
- ❑ Diabetes
- ❑ Ear infections (chronic/numerous)
- ❑ Emotional disturbances
- ❑ Frequent headaches/migraines
- ❑ Frequent stomach aches
- ❑ Glasses ❑ Contact lenses
- ❑ Digestive problems
- ❑ Heart/blood disease
- ❑ Attention deficit disorder
- ❑ Kidney disease
- ❑ Physical handicap
- ❑ Seizure disorder
- ❑ Special dietary regimen
- ❑ Surgeries
- ❑ Throat infections (chronic/numerous)
- ❑ Head injuries
- ❑ Hearing impairment
  Uses hearing aid ❑yes ❑no

Allergies. List all known allergies for this student (include medications, foods, insects, environmental, etc.):

A physician has prescribed the use of an Epi-Pen for _____ allergy. ❑yes ❑no

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Please complete this section if your child has been diagnosed with ANY of the items above.
Number of times child has been taken to an emergency room for an episode in the past 12 months:

Describe the type of symptoms your child experiences:

Is there anything that triggers the symptoms?

What usually helps if an episode occurs?

Medications child takes for this condition: Name, dose, frequency:

List any other medications this student takes on a routine basis:

Asthma: Does your child use a peak flow meter? ❑yes ❑no If yes, what is the child's best peak flow?

I know of no health reason(s), other than the information indicated on this form, why my child should not participate in any school activity. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. I understand that it is my responsibility to provide emergency medications my child may need. Transportation by ambulance is authorized if required.

Parent/legal guardian signature_____Date_____

Medication Permission Form

Student name _____ Grade level _____

Permission for the administration of over-the-counter medications during school attendance.
I give my permission for authorized school personnel to administer over-the-counter medications/treatments to the above named student for minor discomforts and injuries. I understand that these medications will NOT be given for fever.

Please initial all the following to allow authorized personnel to give:

_____ Cough drops

_____ Acetaminophen (equivalent for Tylenol)

_____ Ibuprofen* (Advil, Motrin or equivalent)
**Students under age 12 will only be given junior strength ibuprofen. This will not be supplied by the district.*

Note: Stock bottles of acetaminophen, regular ibuprofen and cough drops are provided in each building. If students bring any over-the-counter medication (including junior strength ibuprofen) from home, it must be in the original container and be clearly labeled with child's name. The school district no longer stocks junior strength ibuprofen for students.

I understand that any school employee who administers any of the above medications, in accordance with the prescription and/or over the counter directions, to my student shall not be liable for damages as a result of an adverse reaction suffered by the student due to this administration. **I further acknowledge that the above student has taken the medication(s) previously (or the initial dosage) and has experienced no adverse reactions.**

Parent/legal guardian signature_____Date_____

Permission for the administration of prescription medications during school attendance.

Medication: _____Dosage:_____ Date of initial dose: _____

Reason for Rx: _____

Time of day Rx to be given: _____ Anticipated duration of Rx at school: _____

Physician comments:

Physician signature*_____Date_____

Parent/legal guardian signature*_____Date_____

**REQUIRED for all students in grades K-12 in order to authorize the dispensation of above prescription medication(s) at school.*

Note: Any prescription medication is to be brought to school in the original container appropriately labeled by the pharmacy stating:
1. Name of the student
2. Name of medication

3. Dosage and time to be administered
4. Number of days to be administered
5. Current prescription date