



2016-17 ES NEW STUDENT HEALTH HISTORY & PERMISSION FOR OVER-THE-COUNTER MEDICATION AT SCHOOL

Student Name: _____ Sex: _____ Grade: _____ Birthdate: _____

Each time your child receives medication, he/she will be given a note stating when and what was administered. I give my permission for the following medication to be given to my son/daughter in the Health Room.

Please CHECK (✓) all medications that school may give:

- Acetaminophen (e.g. Tylenol): one dose every 4-6 hours. Dose by age/weight.
Children's Chewable: 80 mg. tablet; Junior Chewable: 160 mg. tablet; Regular Strength: 325 mg. tablet
- Ibuprofen (e.g. Advil): one dose every 6-8 hours. Dose by age/weight.
Oral Suspension (liquid) 100 mg./teaspoon; Junior Chewable: 100 mg. tablet
- Pseudoephedrine (e.g. Sudafed): 30 mg. tablet, one dose every 4-6 hours Must be at least 6 years old.
- Throat lozenge/cough drop: one every 4 hours
- Tums: 1-2 chew tabs as needed

I give my permission for the treatment and care of minor illnesses and injuries, including application of eye drops, removal of splinters, application of insect repellent and sunscreen.

I authorize health information for disclosure to necessary school and/or medical staff to aid appropriate health care.

Parent Signature: _____ Print Name: _____

Home Phone: _____ Work/Daytime Phone: _____ Cell: _____

Email Address: _____

Alternate Parent/Health Contact: _____ Relationship: _____

Home Phone: _____ Work/Daytime Phone: _____ Cell: _____

DOES YOUR CHILD HAVE:

ADD/ADHD? Yes No On medication: Yes No Name of ADD medication: _____

Asthma or reactive airway disease? Yes No Inhaler: Yes No Name of inhaler: _____

Diabetes? Yes No Use insulin: Yes No Blood sugar testing: Yes No

Severe (body-wide) food allergy? Yes No Epi Pen: Yes No Check: Fish Nuts Other: _____

Lactose Intolerance? Yes No Other dietary restrictions/modifications: _____

Severe (body-wide) bee stinging allergy? Yes No Epi Pen: Yes No Describe reaction: _____

Severe (body-wide) latex allergy? Yes No Epi Pen: Yes No Describe reaction: _____

Other severe allergy? Yes No List allergy/ies and treatment: _____

Allergic to any medicine? Yes No List medicine/s student is allergic to: _____

Seizure disorder? Yes No Type of seizures: _____ On seizure medication: Yes No

Name of seizure medication: _____ Date of last seizure: _____

Heart condition/problem? Yes No If yes, please explain: _____

Other major health concern/s? Yes No List: _____

HEALTH HISTORY

Birth or development abnormalities: _____

Serious injuries: _____

Fractures/Breaks: _____

Operations: (Circle) Appendix Tonsils/ Adenoids Ear Tubes Other: _____

Serious illness: _____

Hospitalized (other than for above): _____

Please check those that apply:

- Colds (frequent)
- Bronchitis/Pneumonia (Circle which)
- Tonsillitis (frequent)
- Ear Infections (frequent))
- Impaired Hearing Hearing Aids? Yes No
- Stomach Disorders Medications? Yes No Name of stomach medication/s: _____
- Diarrhea (chronic)
- Constipation (chronic) Medications? Yes No Name of constipation medication/s: _____
- Headache (frequent)
- Migraines Medications? Yes No Name of migraine medication/s: _____
- Skin Eczema Psoriasis
- Mobility/Walking Concerns List: _____
- Psychological Condition? Yes No Name of condition: _____
 Medications? Yes No Name of medication/s for psych condition: _____
- Bedwetting
- Daytime toileting concerns/issues (explain below)
- Glasses/Contacts Always Reading Only
- Impaired Vision (Other than glasses)
- Other: _____

Please explain any of above conditions and list any medications student takes at home that are not listed above:
