2016-17 HS 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 school may give:

❒ Acetaminophen (e.g. Tylenol): one/two tabs every 4-6 hours
Regular Strength: 325 mg tab; Extra Strength: 500 mg tab

❒ Ibuprofen (e.g. Advil): one/two tabs every 6-8 hours
Regular Strength: 200 mg tab

❒ Pseudoephedrine (e.g. Sudafed): 30 mg tab: one/two tabs every 4-6 hours

❒ Throat lozenge/cough drop: one every 4 hours

❒ Tums: 2-4 chew tabs as needed

I give my permission for the treatment and care of minor illnesses and injuries, including the 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 sting 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: ________________ Daily seizure medication? ❒ Yes ❒ No

Emergency seizure medication? ❒ Yes ❒ No Name of medication: ______________ Date of last seizure: ________

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

Other major health concern/s? ❒ Yes ❒ No List: ____________________

OVER OVER OVER (Please continue on back side) OVER OVER OVER

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: ______________________________

❒ 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:

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