



2016-17 HS RETURNING STUDENT HEALTH UPDATE & 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:
Psychological condition? Yes No Medications? Yes No Name of medication/s psych condition:
Migraines? Yes No Medications? Yes No Name of migraine medication/s:
GI/stomach condition? Yes No Medications? Yes No Name of medication/s GI condition:
Other major health concern/s? Yes No List:

Since last school year, has your child had any changes in health/medical conditions? (such as: operations, fractures, hospitalizations, changes in medications taken at home, other than listed above). If so, please explain:

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