2018-19 MS NEW STUDENT HEALTH HISTORY & PERMISSION FOR OVER-THE-COUNTER MEDICATION AT SCHOOL

Mosinee School District "Expect the Best"

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 Chew (e.g. Tylenol): one dose every 4-6 hours - dose by age/weight
  Junior Chewable: 160 mg tab; Regular Strength: 325 mg tab; Extra Strength: 500 mg tab
- ❒ Ibuprofen (e.g. Advil): one dose every 6-8 hours - dose by age/weight
  Junior Chewable: 100 mg tab; Regular Strength: 200 mg tab
- ❒ Pseudoephedrine (e.g. Sudafed): 30 mg tablet, one dose every 4-6 hours
  Less than 12 years old: one tab; 12 years old and older: two tabs
- ❒ 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 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 Activity restriction? ❒ Yes ❒ No Please explain condition and restriction: _____

_____

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 psychological 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:

_____

_____

_____

_____

_____