2018-19 MS Returning Student Health Update & 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.
  Children's Chewable: 160 mg tablet; Regular Strength: 325 mg tablet; Extra Strength: 500 mg tablet
- ❒ Ibuprofen (e.g. Advil): one dose every 6-8 hours. Dose by age/weight.
  Junior Chewable: 100 mg tablet, Regular Strength: 200 mg tablet
- ❒ Pseudoephedrine (e.g. Sudafed): 30 mg tablet, one dose every 4-6 hours.
  Less than 12 years old: one tablet; 12 years old and older: two tablets
- ❒ 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 Activity restriction? ❒ Yes ❒ No Please explain condition and restriction: _____

_____

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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