Confidential Emergency Health Information Form 2017 - 2018

PLEASE COMPLETE AND RETURN TO THE HEALTH OFFICE BY AUGUST 15th, 2017.
This form is to be completed ANNUALLY.

Student's Name: _____ **Birth date:** _____ **Sex: F M Grade:** _____

Physician's Name: _____ **Physician's Phone:** _____

Parent/Guardian 1		**Parent/Guardian 2**	
Relationship		**Relationship**	
Home Phone		**Home Phone**	
Work Phone		**Work Phone**	
Cell Phone		**Cell Phone**	
Email		**Email**	

CURRENT HEALTH CONDITIONS:

*(Circle the health conditions/concerns that your child has NOW & that may affect your child at school)

❑ ADD/ADHD	❑ Mental Health Diagnosis:
❑ Severe Allergy/Anaphylaxis* (requiring emergency medication) To what? _____ Does your child need medications at school to treat an allergic reaction? ☐ YES ☐ NO *If YES, please contact RN & return Allergy Action Plan to Health Office with the medications.	❑ Hearing Problems: ❑ Vision Problems: (excluding corrective lenses) ❑ Neurological Disorder: ❑ Heart: ❑ GI/Bowel Disorder: ❑ Liver:
❑ Allergy to foods: (Please list food & reaction)	❑ Orthopedic Problem: ❑ Urinary/Kidney:
❑ Allergy to medications: (Please list med & reaction)	❑ Menstrual cramps: Mild/Severe ❑ Recent Operations/Serious injuries:
❑ Allergy to insect bites : (Please list insect & reaction)	
❑ Allergy to pollen	❑ Any other significant conditions or disorders:
❑ Asthma * (Contact RN)	
❑ Diabetes* (Contact RN)	
❑ Seizure Disorder* (Contact RN)	
❑ Headaches/Migraines/Past Concussions (Circle those that apply)	• Additional comments/Physical limitations:
❑ Cardiovascular Condition	

Do you give your consent to share relevant health information regarding your child with appropriate school and/or emergency personnel as necessary? This would include permission for communication between the health provider and school nurse to facilitate this process. Yes ____ No _____

MEDICATION:

Is medication needed at home? ☐ **YES** ☐ **NO**

Medications Taken at Home	Dosage/Frequency	Reason
1.		
2.		
3.		

Is medication needed at school? ☐ **YES**** ☐ **NO**

Name of Medication	Dosage/Frequency	Reason
1.		
2.		
3.		

****A Medication Consent Form must be completed for a student to receive prescription medicine at school. The prescription medication must be clearly labeled prescription bottle with the student's name and instructions as specified by the pharmacy. This form and the form for student to carry and self-administer Epi-pen and Inhaler are available from the School Nurse.**

Parental Permission for Over the Counter Medications:

☑ Check one:

- ❑ **May give all medications listed according to the listed dosages for weight and symptoms**
- ❑ **Give ONLY medications checked according to the listed dosages for weight and symptoms**
- ❑ **Do NOT give any medications**

Student's Weight

Please check "yes" to authorize school nurse/staff to give your child the following medications while on campus.

Over-the-counter medication dispensed per package directions:	Indications:	Dosage (please circle)	YES
Acetaminophen (generic Tylenol)	Pain reliever/fever reducer	36 - 47 lbs: 160 mg 48 - 71 lbs: 320 mg 72 - 95 lbs: 480-500 mg 96 lbs +: 500-650 mg	
Ibuprofen (generic Advil/Motrin)	Pain reliever/fever reducer	36 - 47 lbs: 150 mg 48 - 71 lbs: 200 mg 72 - 95 lbs: 300 mg 96 lbs +: 400 mg	
Tums (Calcium Carbonate)	Stomach pain/upset stomach	1 or 2 tablets	
Cough drops	Cough/throat irritation	1 cough drop	
Triple antibiotic ointment	Minor scrapes/cuts	As directed	
Calamine lotion	Itching/skin rashes	As directed	
Hydrocortisone 1% lotion	Itching/skin rashes	As directed	

PRINT Parent/Guardian Name **SIGNATURE** **DATE**

THE INFORMATION ON THIS FORM IS VERY IMPORTANT FOR THE HEALTH AND SAFETY OF YOUR CHILD. IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL OFFICE OR SCHOOL NURSE IF THERE ARE ANY CHANGES OR UPDATES IN YOUR CHILD'S HEALTH.