Confidential Emergency Health Information Form 2016 - 2017

PLEASE COMPLETE AND RETURN TO THE HEALTH OFFICE BY AUGUST 15th, 2016.

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) ❑ Allergy to insect bites : (Please list insect & reaction)	❑ Menstrual cramps: Mild/Severe ❑ Recent Operations/Serious injuries:
❑ Allergy to pollen ❑ **Asthma * (Contact RN)** ❑ **Diabetes* (Contact RN)** ❑ **Seizure Disorder* (Contact RN)**	❑ Any other significant conditions or disorders:
❑ Headaches/Migraines/Past Concussions (Circle those that apply) ❑ Cardiovascular Condition	• Additional comments/Physical limitations:

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

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	5yrs age: 160mg 6-11yrs: 320mg 12 yrs +: 500-650mg	
Ibuprofen (generic Advil/Motrin)	Pain reliever/fever reducer	5 yrs: 100mg 6-11 yrs: 200mg 12 yrs+: 400mg	
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.