Dear Parents,

Below is a packet of health forms. Please complete the paperwork significant to your child **only** and **disregard** any forms that do not apply to your child. A physical exam within one year of entry to school and current immunization record is also required.

Thank you,

Eleanor Hurley, RN

Eleanor Hurley, RN
508-583-6875, ext. 7990

STUDENT HEALTH INFORMATION

*****PLEASE RETURN TO THE HEALTH OFFICE AS SOON AS POSSIBLE*****

(PLEASE PRINT CLEARLY)

STUDENT NAME____________________________**DOB**_____________ ___**M**___**F**__
(last) (first)

ALLERGIES: ____

PARENT/GUARDIAN:
____

ADDRESS: ____

CITY/TOWN: ____

HOME PHONE: ______________________________________**WORK**

PHONE_________________________**CELL PHONE:** _________________________

EMAIL:_______________________________________

I GRANT PERMISSION FOR:____
(student name)

TO RECEIVE:

______**TYLENOL (Acetaminophen 325-1000mg every 4-6 hours for pain/headache)**

______**MOTRIN (Ibuprofen 200-600mg every 4-6 hours for pain/headache)**

______**TUMS (Antacid 1-2 tabs as needed for upset stomach)**

______**ANTIBIOTIC OINTMENT (for minor cuts/abrasions)**

REQUEST FROM THE NURSE/STAFF OF CARDINAL SPELLMAN HIGH SCHOOL

Parent's signature: ____________________________________Date: __________________

Doctor's Name: ______________________________________ Phone:_________________

WE ARE UNABLE TO DISPENSE ANY OVER THE COUNTER MEDICATION TO YOUR CHILD WITHOUT THIS FORM COMPLETED YEARLY.

Does your child have any current medical conditions or problems that we should be aware of?

____

____

____

Has your child had any significant injuries within the last year (concussions, surgery, broken bones)? Please include dates.

____

____

____

Is your child currently taking any medications (including over the counter medication and/or supplements?

____

____

____

PARENT/GUARDIAN AUTHORIZATION
PRESCRIPTION MEDICATION ADMINISTRATION

Name of Student ________________________________ DOB ____/____ /_____

Parent/Guardian Printed Name ____

Home phone _________________________ Cell _______________________

Work phone _________________________ Emergency ___________________

Other person(s) to be notified in case of medication emergency

Name ____________________________ Phone ______________________

Name ____________________________ Phone ______________________

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

____

____

My son/daughter has the following food or drug allergies:

____

____

I consent to have the school nurse or school personnel designated by the school nurse administer the medication prescribed by: ______________________________________
Licensed Prescriber

to__________________________________
Student's Name

I give permission for my son/daughter to self-administer medication, if the school nurse determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/guardian signature ___________________________________ Date___________
Relationship to Student __________________________________
Address ____

PARENT/GUARDIAN AUTHORIZATION
NON-PRESCRIPTION MEDICATION ADMINISTRATION

Name of Student ________________________________ DOB ____/____ /_____

Parent/Guardian Printed Name ____

Home phone _________________________ Cell _________________________

Work phone _________________________ Emergency ___________________

Other person(s) to be notified in case of medication emergency

Name _____________________________ Phone ______________________

Name _____________________________ Phone ______________________

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

____

____

My son/daughter has the following food or drug allergies:

____

____

I consent to have the school nurse or school personnel designated by the school nurse administer the medication prescribed by:______________________________________

Licensed Prescriber

to__________________________________

Student's Name

I give permission for my son/daughter to self-administer medication, if the school nurse determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/guardian signature __________________________________Date_____________
Relationship to Student ___________________________________
Address ____

MEDICATION ORDER FOR ANAPHYLAXIS
TO BE COMPLETED BY A LICENSED PRESCRIBER:
PHYSICIAN, NURSE PRACTITIONER OR OTHER AUTHORIZED BY CHAPTER 94C

Name of Student ________________________________ DOB _____/_____/_____

Address____ Grade _______________

Name of Licensed Prescriber _______________________________ Title _______

Business Telephone # _____- ______-_____ Emergency Telephone # ______- ______- _____

Type of Allergy ____

Other Medical Condition(s)*

____

Other Medications Taken by Student*

____

In the event of exposure to allergen: ☐ Do Immediately

☐ Do when signs/symptoms of allergic reaction appear

☐ 1.) Administer Oral Benadryl ______ cc p.o.

☐ 2.) If signs/symptoms worsen or are unresolved with oral Benadryl within ____ min or, ORAL BENADRYL NOT ORDERED please administer:

☐ Epi-Pen s.c

☐ Epi-Pen Jr. s.c.

☐ 3.) If signs/symptoms unresolved with Epi-Pen/Epi-Pen Jr. s.c. within ____ min administer repeat dose of:

☐ Epi-Pen s.c

☐ Epi-Pen Jr. s.c.

Life threatening allergic reactions are given epinephrine immediately.
911 called whenever epinephrine is administered.

Other orders: ____

Special side effects, contraindications, or possible adverse reacting to be observed:

____

Consent for self-administration (provided that R.N. determines it is safe and appropriate)
Yes ______ No ______
Prescriber Signature ___________________________________Date ______________
*If not in violation of confidentiality

PRESCRIPTION MEDICATION ORDER
TO BE COMPLETED BY A LICENSED PRESCRIBER:
PHYSICIAN, NURSE PRACTIONER OR
OTHER AUTHORIZED BY CHAPTER 94C

Name of Student ______________________________DOB _____/_____/_____

Address____ Grade ________

Name of Licensed Prescriber ______________________________Title _______

Business Telephone No. _________- ________-_________

NAME OF MEDICATION____

Dosage _________________________

Frequency _________________________________

Other Orders

____

____

____

Special Side Effects, Contraindications, or possible adverse reactions to be observed:

____

____

____

Consent for self-administration (provided that R.N. determines it is safe and appropriate)
Yes _______ No _______

Prescriber Signature _______________________________Date ____________