STUDENT MEDICAL HISTORY AND OVER THE COUNTER MEDICATION CONSENT

STUDENT NAME_____GRADE_____TEACHER_____

PHYSICIAN NAME & PHONE NUMBER_____ (_____)_____

DOES THIS CHILD CURRENTLY HAVE OR EVER HAD ANY OF THE FOLLOWING :

	YES	NO		YES	NO
ASTHMA (current use of INHALER OR NEBULIZER) **(current usage- must have 2 forms filled out and on file in nurse's office)**	_____	_____	DIABETES (CURRENTLY USE INSULIN OR PILLS)	_____	_____
			CHRONIC BOWEL/BLADDER ISSUES	_____	_____
SEASONAL ALLERGIES	_____	_____	MIGRAINES OR FREQUENT HEADACHES	_____	_____
SEIZURES **(need SEIZURE FORM filled out)**	_____	_____	HIGH BLOOD PRESSURE	_____	_____
HEART MURMUR	_____	_____	FREQUENT NOSE BLEEDS	_____	_____
ADHD	_____	_____	ANXIETY	_____	_____
BIPOLAR	_____	_____	DEPRESSION	_____	_____
STOMACH ULCERS	_____	_____	OTHER HEALTH ISSUES NOT LISTED:_____		

PLEASE LIST SURGERIES:_____

MEDICATIONS (INCLUDING INHALERS) TAKEN EVERY DAY AT HOME:_____

*********If your child will need medication daily at school, please make sure to fill out a PRESCRIPTION MEDICATION FORM.* ***No medication can be carried by students at any time. To self-carry an inhaler, students must have prior Dr's authorization. This must be updated each year.***

ALLERGY TO MEDICATIONS:_____ ALLERGY TO WASP/BEE STINGS: **YES NO**

ALLERGY TO FOOD:_____ALLERGY TO LIDOCAINE OR OTHER NUMBING MEDICATION: **YES NO**

OTHER KNOWN ALLERGIES:_____

*********If your child is allergic to wasp/bee stings, lidocaine, food, or medications listed below please fill out an ALLERGY FORM so we know what to do if your child comes in contact with the allergen. If your child will need the cafeteria to substitute meals or drinks for any food allergy, also fill out the SPECIAL MEAL FORM and have a doctor sign it.* ***All forms can be found in our office, can be sent home by calling and requesting at 660-499-2202 x126, or on the school web site under nursing at www.sherwoodk12.net.***

SCREENINGS: *Age appropriate health screenings are provided as time permits and are different for each grade. If you DO NOT wish for your child to participate in any one of the following screenings, please write* ***NO*** *next to the screening you wish for your child to opt out of.*

VISION _____ HEIGHT _____ WEIGHT _____ BMI _____ BLOOD PRESSURE _____ SCOLIOSIS _____

*********The following over the counter medications are generic and offered to students throughout the day. Please write* ***NO*** *next to each medication you DO NOT WISH for your student to be given while at school. If the line is left blank, it will be assumed that it is alright to give that medication to your student. I further understand that nursing staff will follow package directions and not be held liable for an adverse drug reaction. In the event that my child needs over the counter medications at least once a week, a physician signature may be required, and I may be expected to supply the medication. Students are allowed to keep cough drops, lotion, and Chap Stick with them in the classroom.*

TYLENOL _____ MOTRIN _____ BENADRYL _____ BENADRYL OINTMENT _____ SORE THROAT SPRAY _____ TUMS _____
COUGH DROPS _____ ORAJEL _____ VISINE EYE DROPS _____ EARACHE RELIEF DROPS _____

*********Please medicate your student prior to sending them to school if you feel they may need medication before 11:00. To prevent an accidental overdose, Tylenol, Motrin, and Benadryl* ***WILL NOT*** *be given out prior to 11:00. The medications listed above are the only ones kept routinely in the nurse's office. If your child will need something different, please feel free to bring the medication in a labeled bottle for them. All health information shared with us will be kept confidential and will only be shared with school personnel on a need to know basis. This information may also be shared with emergency personnel in the event of an emergency at school.*

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____