North Union School District

Grade_______

Name of Child ______________________________ Birth Date _______________ Male Female

Last First Circle One

PRESENT HEALTH HISTORY

To best serve your child's education and to get to know your child better, we need to find out if there are any health problems that could affect your child's performance or attendance at school. Please check any that apply to your child.

Yes No

_____ _____ ADD/ADHD Diagnosis

_____ _____ VISION Glasses ____________ Contacts ____________ Eye Dr.______________

_____ _____ HEARING, EAR TUBES, INFECTIONS? _________________________

_____ _____ ASTHMA Medication _________________________ Inhaler with student YES / NO

(If yes, Asthma Action Card & Authorization to Administer Medication need to be on file.)

_____ _____ ALLERGIES (medications/environment/food, please name)____________________________________

_____ _____ MEDICATIONS

List medications taken at home:____

List medications taken at school:____

_____ _____ DIABETES On insulin? _________ Has insulin pump? __________

(If yes, a Diabetes Medical Management Plan needs to be on file.)

_____ _____ Is there any other HEALTH INFORMATION about your child which you think may be helpful for the school to know? If yes checked, please provide additional information.

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_____ _____ Is it OK to share this information with your child's teachers?

Information is confidential and only shared as needed.

The following may be given to my child by the school nurse or qualified staff person for illness during school time.

_____ _____ Acetaminophen (Tylenol)… Given according to age/weight every 4 hours as needed.

_____ _____ Ibuprofen 200 mg (Advil)…5th grade only….1 or 2 tablets every 4 hours as needed.

_____ _____ Hydrocortisone or Benadryl Cream for insect bites.

_____ _____ Triple antibiotic ointment for scrapes, cuts.

_____ _____ Benadryl or Generic allergy liquid as directed according to age/weight.

I have read all information pertaining to my son/daughter. I verify that all information given is correct and accurate. In the event of any changes that would affect this information, I will contact the school nurse's office to make the appropriate updates.

Daytime phone for parent/guardian:____________________ Cell:________________ Email:__________________

Signature of parent/guardian: ____ Date:__________________

North Union School District

Authorization to Administer Medication & Permission for Self-Administration of Asthma Medication

To insure compliance with the Board policy for administering medication at school, the following procedure must be followed: ALL MEDICATION MUST BE DELIVERED TO AND FROM SCHOOL BY PARENT/ LEGAL GUARDIAN IN THE ORIGINAL AND PROPERLY LABELED CONTAINER. The container must include the following information: student name, medication, dosage, time, route, and Physician. Written authorization and instructions must be provided by parent/legal guardian for all medication. The school staff shall have the right to contact the prescribing Physician to confirm or clarify medication instructions. The time of medication administration may need to be altered slightly to fit your student's schedule.

Student:________________________________ Age:_____________ Grade/Room:____________

Prescribed By:___________________________________ Phone:_____________________________

Name of Medication:_____________________________ Pharmacy:__________________________

Health Condition:___________________________________

Please give the above medication:

Amount:__________ Time:___________ Start Date:_________ End Date:_________

Amount Sent:__________________

***If any medication is left after the last day of school it will be discarded within 24 hours.**

***Medication will not be given if it has expired or it has an improper label. Please check the container prior to sending.**

I request that the prescribed drugs or medication be administered according to these written directions. I request that this medication be given by a qualified staff person. The student has experienced no previous side effects from the medication. I further agree that the school personnel may contact the prescriber as needed and that medication information may be shared with school personnel as needed.

☐ PERMISSION FOR SELF-ADMINISTRATION OF ASTHMA OR AIRWAY CONSTRICTING MEDICATION. Provided the above requirements are fulfilled (labeled with name, medication, dosage, route, time and Physician, and written authorization and instructions are provided by the parent/guardian), a student with asthma or other airway-constricting disease may possess and use the student's medication while in school and at school-sponsored activities. If the student abuses the self-administration policy, the ability to self-administer may be withdrawn. I understand the school district and its employees acting reasonably and in good faith shall incur no liability as a result of any injury arising from self-administration of medication by the student. The student is responsible for maintaining a self-administration record.

Parent/Guardian Signature:_______________________________________ Date:__________________

Home Phone:_________________________________ Cell Phone:______________________________