North Union Community School District – Swea City Campus

HEALTH INFORMATION & CONSENT FOR OVER THE COUNTER MEDICATION

Student Name: _____ **DOB:** _____ **Age:** _____

Grade: _____ **Male / Female** 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/Mental Health Diagnosis - Medications:** _____
- ☐ ☐ **VISION** **Glasses** _____ **Contacts** _____ **Eye Dr:** _____
- ☐ ☐ **HEARING, EAR TUBES, INFECTIONS?** _____
- ☐ ☐ **ASTHMA** **Medication** _____ **Inhaler w/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?** _____
- ☐ ☐ 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.

  _____

  _____

- ☐ ☐ **Is it OK to share this information with your child's teacher?** *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.

YES NO

- ☐ ☐ **Acetaminophen (Tylenol) or Children's Chewable** – given according to age/weight per bottle
- ☐ ☐ **Ibuprofen** – given according to age/weight per bottle
- ☐ ☐ **Hydrocortisone or Benadryl Cream** – for insect bites
- ☐ ☐ **Triple Antibiotic Ointment** – for scrapes, cuts
- ☐ ☐ **Cough Drops** – 1 every 2 hours as needed for sore throat and/or cough
- ☐ ☐ **Antacid Tablets (Tums)** – given according to age, per bottle, for upset stomach
- ☐ ☐ **Eye Drops (Clear Eyes)** – for minor eye irritations
- ☐ ☐ **Oral Pain Relief** (Benzocaine 20%) – for mouth sores or tooth pain
- ☐ ☐ **Bio-freeze type ointment** (menthol 3.1%) – roll on for sore muscles or joints

I have read all information pertaining to my child. 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.

Parent/Guardian Signature: _____ **Date:** _____

Phone: _____ **Email:** _____

PLEASE COMPLETE BOTH SIDES OF FORM

Student Name: _____ **DOB:** _____ **Age:** _____

Grade: _____ **Male / Female** circle one

EMERGENCY CONTACT INFORMATION

Please provide a minimum of 2 emergency contacts in the order they should be contacted.

Name _____ Relationship _____ Ph. # _____

Name _____ Relationship _____ Ph. # _____

HEARING, VISION, DENTAL, HEIGHT & WEIGHT SCREENING CONSENT

I also give permission for the school nurse or other trained personnel to perform routine health screening that may include hearing, vision, dental, height, and weight. Parent or guardian contact will be made with abnormal screenings. I authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to the form. **This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained your child's health record.**

Parent/Guardian Signature: _____ **Date:** _____

PLEASE COMPLETE BOTH SIDES OF FORM