North Union High School
Student Health Update

Student Name _____ Birth Date _____ Grade_____
Last *First*

Yes **No**

_____ _____ ADD/ADHD Diagnosis

_____ _____ SEIZURES/EPILEPSY

_____ _____ DEPRESSION/ANXIETY

_____ _____ BLOOD PRESSURE PROBLEMS

_____ _____ MIGRAINES

Family Doctor Name	
Dentist Name	
Speciality Doctors	

_____ _____ VISION Glasses _____ Contacts _____ Eye Dr._____

_____ _____ 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.)

_____ _____ Recent surgeries, serious injuries, health or emotional concerns:

_____

_____

_____ _____ I give my permission to share this information with school personnel that needs to know for my child's safety and success in school (teachers, para-professionals, dietary dept., etc)
Information is confidential and only shared as needed.

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.

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:_____