Stewart County Schools

SCHOOL HEALTH INFORMATION AND OVER THE COUNTER MEDICATION AUTHORIZATION

This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.

Grade:_____ Teacher_____ DOB_____

Student's Name _____ female_____ male_____

MEDICAL PROBLEMS (check all that apply/use an additional sheet to specify (if necessary)

Asthma_____ Sickle Cell_____ Seizures_____

Diabetes _____ Cancer _____ Seasonal Allergies_____

ADHD/ADD_____

MEDICAL PROBLEMS (check all that apply/use additional sheet to specify (if necessary) MEDICAID Yes No ADHD

Does your child take medication at home? Please explain

_____

Will your take medication at school? please explain_____

_____

Physical Handicaps/ Mental Health Issues (Explain):

_____

List names of school age siblings: _____, _____,

_____, _____, _____

Emergency Contact Information: (Parents will be contacted first, unless noted otherwise)

Mother/ Guardian _____ Father /Guardian _____

Home #_____Home#_____

Work #_____Work#_____

Cell#_____Cell#_____

Emergency Contact:

Name _____Relationship _____Phone#_____

Name _____Relationship _____Phone#_____

In case of an emergency, the school has my permission to transport my child to the nearest hospital via EMS for further treatment /evaluation. Stewart County School personnel have my permission to contact my child's physician for further medical information.

Child's Healthcare Provider_____Phone#_____

Hospital Name _____

COMPLETE FRONT AND BACK AND SIGN FORM

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Over the Counter medication Authorization

Attention Parents:

During the school year it may be necessary for your child to be given over the counter medication for minor illnesses such as; headache, stomach ache, cough, sore throat and fever (low grade). **Please check each medication you authorize the school nurse to give. Without you checking off medication or completing and signing form, we will not be able to give any over the counter medication at school.**

___ Tylenol (acetaminophen)

___ Ibuprofen (Advil, Motrin)

___ Tums

___ Kids Pepto tablets

___ Cough drops

___ Benadryl

___ Throat spray

I **give permission for my child** (Name) _____ to be given over the counter medication (s) checked above at school as needed.

Parent's Signature: _____ Date: _____

I **do not give permission for my child** (name) _____ to be given over the counter medication (s). I do understand there may be a chance that I will be called and have to pick my child up from school.

Parent's Signature: _____ Date _____