Student Medical Information 2023-24

Name: _____Date of Birth: _____Grade: (23-24) _____

Medical Conditions: _____

Medications: _____

Allergies: (Food, Drug, Insect, Other) _____

Health History		Comments			Comments
Diagnosis of Asthma?	Y/N		Eye/Vision problems?	Y/N	
Wakes at night coughing?	Y/N		Ear/Hearing problems?	Y/N	
Birth Defects?	Y/N		Positive TB skin test?	Y/N	
Developmental Delay?	Y/N		TB disease past or present?	Y/N	
Blood Disorder?	Y/N		Bone/joint problems?	Y/N	
Diabetes?	Y/N		Blood Pressure Problems?	Y/N	
Passed out?	Y/N		Serious injury or illness?	Y/N	
Seizures?	Y/N		Head Injury? Concussion?	Y/N	
Heart Problems?	Y/N		Tobacco use? (type, frequency)	Y/N	
Shortness of Breath?	Y/N		Alcohol/drug use?	Y/N	
Heart Murmur?	Y/N		Family history of sudden death before age 50? Cause?	Y/N	
Dizziness or chest pain with exercise?	Y/N		Hospitalizations? When? What for?	Y/N	
Loss of function of one of paired organs? (Eye, ear, kidney, testicle)	Y/N		Surgery? When? What for?	Y/N	

Medication: If your child needs to take medication at school, please complete a Medication Authorization Form. This form can be found on the district website at this link: http://tremontil.apptegy.us/o/tremont-district/browse/15906

Action Plans: Does your child have **Asthma**, **Food Allergy**, **Seizures**, or any other **Allergy/Anaphylaxis**? If so, please complete an action plan and submit it to the office. These forms will be kept on file so that we know how best to care for your child should an emergency occur. The forms can be found on the district website at this link: http://tremontil.apptegy.us/o/tremont-district/browse/15906

By signing below, I certify that the above information is current and correct. If emergency treatment is required for this child, and the parent/legal guardian cannot be reached immediately, my signature empowers the school authorities to seek medical attention for my child, which may include transporting my child, via ambulance, to a hospital emergency room. My signature below is not sufficient for release of confidential information protected by federal law.

Hospital Preference: _____

Parent/Guardian Signature: _____DATE: _____

PLEASE SEE BACK SIDE OF THIS PAGE FOR IMPORTANT INFORMATION REGARDING MEDICATION GIVEN AT SCHOOL →

PARENT/GUARDIAN PERMISSION FOR MEDICATION ADMINISTRATION

STUDENT: _____ GRADE (23-24): _____

Please mark any of the following medications which you will allow your child to receive at school:

_____ **ACETAMINOPHEN (Tylenol)**
Will be given according to package instructions based on weight/age. May be given every 4-6 hours as needed for minor aches and pains.

_____ **IBUPROFEN (Motrin, Advil)**
Will be given according to package instructions based on weight/age. May be given every 6-8 hours as needed for minor aches and pains.

_____ **BENADRYL CREAM (Diphenhydramine)**
Temporarily relieves pain and itching associated with insect bites, minor burns, sunburn, minor skin irritations, minor cuts, scrapes, and rashes. Benadryl cream is an antihistamine. It works by blocking the action of histamine, which reduces the symptoms of an allergic reaction. May be applied every 6-8 hours.

_____ **TUMS (Antacid tablets)**
Relieves acid indigestion, heartburn, sour stomach, and upset stomach associated with these symptoms. Dosage is 1-2 tablets, not to exceed 6 tablets in a 24-hour period.

_____ **NEOSPORIN OINTMENT (Triple antibiotic)**
For treating and preventing infection due to minor cuts, scrapes, and burns. Neosporin ointment is an antibiotic combination. It works by killing sensitive bacteria on the skin or in wounds.

_____ **COUGH DROPS**
A cough drop is a small, sometimes medicated tablet intended to be dissolved slowly in the mouth to temporarily stop coughs and lubricate and soothe irritated tissues of the throat (usually due to a sore throat), possibly from the common cold or influenza.

_____ **ARTIFICIAL TEARS**
Artificial tears are eye drops used to lubricate dry eyes and help maintain moisture on the outer surface of the eyes. May also be used to flush foreign objects from eyes.

Ibuprofen (200mg) and Tylenol (325mg and 500mg) tablets will be provided by the school. Please note, if your child can take only liquid or chewable ibuprofen or acetaminophen, please provide this to the office and label the package with your child's name.

All medications will be given according to package instructions and only with parent/guardian permission as indicated by your signature below. These are the only medications that may be given without a specific doctor's order. If your child needs to have any other medication, please provide a doctor's order and complete the School Medication Authorization form.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____