

RINGWOOD PUBLIC SCHOOLS

121 CARLETONDALE ROAD
RINGWOOD, NJ 07456



Phone: 973-962-7028 • Fax: 973-962-9211

Student's Name: _____

School Year: _____ **Grade & Teacher/Homeroom** _____

Home Phone _____ **Parent Cell Phone** _____

Please indicate if you wish the nurse to share medical information with teachers/administrators on an as needed basis.

YES NO

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

Migraines Medication used: _____

Diabetes: Type: _____

Asthma: Triggers: _____
Medications Used: _____ How often: _____

Bee Sting Allergy: Type of reaction: _____
Medication (if any) used for reaction: _____

Animal Allergy: Type: _____ Type of Reaction: _____
Medication (if any) used for reaction: _____

Food Allergy: Type: _____ Type of Reaction: _____
Medication (if any) used for reaction: _____

Seasonal Allergy: Time of Year Affected: _____
Type of Reaction: _____
Medication (if any) used for reaction: _____

Medication Allergy: Type: _____
Type of reaction: _____
Medication (if any) used for reaction: _____

Heart Problems/ Chest Pain
 Ear/ Hearing Problems:

Glasses/Contacts
 Depression

Anxiety

Any hospitalizations, surgeries, serious injuries or other health information you feel you should share.

Current medication taken:

I give permission for my child to have "throat" lozenges if needed during the school year.

Date

Parent/Guardian's Signature

**ONLY COMPLETE FOR STUDENTS IN GRADES 4-8
STANDING OVER THE COUNTER MEDICATION ORDER**

Student's Name: _____

School Year: _____ **Homeroom Teacher:** _____

The school nurse has my permission to administer Acetaminophen or Ibuprofen to my child during this school year **only** for the reason(s) indicated below.

CHOOSE ONE AND CHECK DOSAGE

- Acetaminophen 325 mg or 650 mg
 Ibuprofen 200mg or 400 mg

Please indicate with a check next to the reasons(s) Acetaminophen or Ibuprofen can be given to your child:

- Headache
 Orthodontic Discomfort
 Dysmenorrhea (painful period)

Please indicate with a check which can be given to your child for indigestion and/or stomach upset when no elevated temperature is noted.

- Gelusil – Antacid/Anti-gas tablets
 TUMS-Antacid

I understand, with my written permission on this form, that my child may be given acetaminophen or ibuprofen once a day at school only for the above reason(s). If my child presents with other symptoms during the day (i.e. sore throat, stomachache) and above symptoms checked are included, no medication can be given.

I further understand that if my child had a headache due to an injury to his/her head, then acetaminophen or Ibuprofen cannot be given.

Acetaminophen or Ibuprofen **will not** be given if your child has temperature of 100 degrees or above.

Acetaminophen or Ibuprofen **will not** be given the first or last periods of the day.

If it becomes apparent that your child is taking Acetaminophen or Ibuprofen too frequently a note will then be required by your private physician giving permission for the nurse to dispense it.

Date

Parent/Guardian Signature

Note: school physicians signature is on file in health clinic.