RINGWOOD PUBLIC SCHOOLS
121 CARLETONDALE ROAD
RINGWOOD, NJ 07456

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

Student Health Information

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 ☐ Glasses/Contacts ☐ Anxiety
☐ Ear/ Hearing Problems: ☐ Depression

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*

This form is valid for the current school year only and must renewed/completed each school year.

Student Health Information

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 physician's signature is on file in health clinic.

This consent form is valid for the current school year only and must renewed/completed each school year.