

Winona-Montgomery Consolidated School District
Winona, MS

A Message from your School Nurses

Our district currently employs a full-time school nurse at each of our campuses. Please remember that **ANY MEDICATION not listed below, whether by prescription or non-prescription, must have a medication form completed by a parent/guardian. The medication must be brought to the school and picked up from the school by the parent/guardian.** Medications cannot be sent home with the student.

Should your child become ill or injured at school, we have a physician's order that allows the school nurse to provide your student with the following medications if he/she deems necessary:

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Tums, Mylanta or generic antacid tablet or liquid
Benadryl
Epi-Pen (ONLY FOR SEVERE ALLERGIC REACTION)
Cough Drops
Neosporin or antibiotic cream or ointment
Hydrocortisone cream or anti-itch cream
Calamine, Caladryl, or Calagel lotion
Vaseline ointment
Carmex or Blistex ointment
Topical anesthetic (First Aid) spray or hydrogen peroxide
Insect sting spray or wipe
Orajel
Anti-fungal cream
Visine
Saline eye drops or saline eye irrigation

_____ My student MAY TAKE OR USE ALL of the above medications **except** those that are circled.

_____ My student MAY NOT TAKE OR USE ANY of the above medications.

Parent/Guardian signature _____ Date _____

Student Name _____ Grade _____

Winona-Montgomery Consolidated School District Student Health Record

_____ Winona Elementary School

_____ Winona Secondary School

Grade _____ Student's Name _____

_____ M _____ F Race _____ Date of Birth _____

Student Lives With: _____ Both Parents _____ Mother _____ Father _____ Guardian

Does Student Have Insurance: Yes/No _____ Date _____ HR Teacher _____

****In case of accident or serious illness, it is necessary that we can get in contact with you, please notify the office immediately if any of your numbers change:**

Mother/Guardian Home _____ Work _____
Cell _____ Email _____

Father/Guardian: _____ Home _____ Work _____
Cell _____ Email _____

****List below two local individuals (friend/relative) who will assume temporary care of your student if you cannot be reached:**

1. Name _____ Relationship to Student _____
Home _____ Work _____ Cell _____

2. Name _____ Relationship to Student _____
Home _____ Work _____ Cell _____

Does your student take any medication? ____ Yes ____ No **Will any medication be taken at school? ____ Yes ____ No

Please list all medications taken at home/school: _____

Please list any allergies: (medications, food, insects, seasonal) _____

Does your student carry: _____ Epi-Pen _____ Inhaler _____ Insulin Pen

Please list any illnesses your student has now or has had in the past:

____ ADHD/ADD/ODD	____ Diabetes	____ Seizures	____ Sickle Cell Anemia
____ Asthma (no meds)	____ Headaches	____ Stomach Problems	____ Vision Problems
____ Asthma (takes meds)	____ Hearing Problems	____ Bone/Joint Problems	____ High Blood Pressure
____ Physical handicap	____ Rheumatic Fever	____ Serious Injury	____ Surgical History
____ Heart defect	____ Nerve Problems	____ Anemia	____ Other Health Problems

Please explain checked illnesses or other issues that you think are important for us to know: _____

****My student will need additional forms for: ____ Food Allergies ____ Seizures ____ Asthma
____ Diabetes ____ Epi-Pen ____ Medications at school ____ Well Child Screenings at School**

I, the parent/guardian of _____ give permission for my student to participate in the school's health program, receive first aid, and health education from the school nurse or other designee of the school. In addition, I give Winona School District staff permission to transport my child for emergencies, medical needs, or school issues as deemed necessary. I also understand that the district will try to locate me in case of emergency at the numbers that I have provided.

Parent/Guardian Signature _____ Date _____