

HEALTH INFORMATION AND MEDICATION FORMS

St. John's Lutheran School
2415 Silas Creek Parkway, Winston-Salem, NC 27103
725-1651

2006-2007

Please take some time to review the following guidelines and fill out the forms as they apply to your child/ren.

- I. Health Information
- II. Medical Release Form
- III. Two Medication Forms

- A. Prescription Medication Form - **Requires a physician or other health care provider signature. Prescription medications cannot be given at school unless this form is completed and on file.** This form is required as for prescription medications that are needed continuously throughout the school year as well as episodic medications such as antibiotics. For that reason, it might be best to keep a few blank copies of the form and take them with you when you see the doctor during times of illness. Then, your health care provider will be able to fill the form out for you at the time of prescription.
- B. Non-prescription (over the counter) Medication Form – Requires only a parent/guardian signature. **This form must be completed in order for your child to receive a non-prescription medication.** Be specific in regards to reason and frequency of medications. **ONE FORM PER MEDICATION/PER STUDENT.**

General standards regarding medication administration:

- 1. Students will be given medications at St. John's Lutheran School ONLY if we have a completed and properly signed medication form. This includes all prescription and over-the-counter medications. If we do not have a completed form, we will attempt to contact you by phone to obtain permission, but if we cannot easily reach you, your child will not be able to receive medication.**
- 2. For the safety of everyone, no child may carry and self-administer medications while at school except for emergency medications** such as inhalants for asthma insulin and glucose tablets for diabetes, or EpiPens for allergic reactions. If emergency medications are needed, the student should keep the medication with him/her at all times in a pocket or desk. If the child is young or the parents want the medication to be kept in the school office, we will do that. Medications **may not** be kept in a backpack in the hallway or other area that is not continuously monitored. All non-emergency medications will be kept in the school office. Please comply with these rules for the safety of everyone. We have a wide variation in age and maturity levels within the student population, and young students especially could be harmed if they accidentally have access to medications. Many medications such as cough syrup and chewable vitamins or pain relievers are pleasant tasting which could easily lead to overdose.
- 3. If a parent or health care provider changes medication administration instructions, a new form should be filled out or written instructions about the change should be sent to the school office.**

Thank you
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PRESCRIPTION MEDICATION Administration Consent Form

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All prescription medications dispensed at the school including students who carry and self administer inhalers/EpiPens/Insulin, must have written instructions **signed by a physician and the parent/guardian.** A new medication consent form must be completed for each school year and whenever there is a change in medication instructions.

Name of student _____ D.O.B. _____
School _____ Grade _____
Diagnosis(es) _____

I give permission to the St. John's staff designated by the school to give the following medication to my child according to the stated instructions and further authorize appropriate school staff to contact my child's physician in regard to the medication if necessary.

_____ Date _____

(For Physician use only)

Medication Name _____	
Dose, Route, and Administration time(s) _____	
<u>Inhaler</u> for asthma – student may carry and self-administer	Yes No
<u>Epi/Pen</u> for severe allergic reaction - may carry and self-administer	Yes No
<u>Insulin</u> for diabetes - may carry and self-administer	Yes No
Effective Date _____ to _____.	
If students carry inhalers/EpiPens/Insulin, it is recommended that back-up medication be stored in the school office. Will the parent be providing a back-up supply of the prescribed medication?	
Yes No	
_____ Physician's Name (please print)	_____ Physician's Phone #
_____ Physician's Address	
_____ Physician's Signature	_____ Date
(Physician's signature verifies approval for the above-described medication and indicates a willingness to communicate with the staff person, as designated by the school, who administers the medication.)	

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A = Absent
 R = Refused
 N = No Show
 D = Discontinued
 H = Half Day
 F = Field Trip

Signature Initials

NON-PRESCRIPTION (Over-the-counter) MEDICATION FORM

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1. A physician's signature is **not required**. **Parent/Guardian signature and instructions for administration must be included.** (One form per student.)
2. Please be very specific when filling out the medication permission form to include the name of the medication, the dosage (how many mg. or tablets), the time the medication is to be given, and if we can repeat the medication such as in 4-6 hours, and reason for administration (e.g. menstrual cramps, headache, pain, etc).
3. We have a supply of these medications – **These are suggested doses only based on manufacturer's labels.** Due to a lack of storage areas, we request that students use our supply of these medications rather than bring another bottle from home

Weight	Age	Tylenol Children 80 mg Chewable	Tylenol Junior 160 mg Chewable	Tylenol Regular Strength 325 mg	Advil (Ibuprofen) Regular 200 mg
36-47	4-5	3 Tablets			
48-59	6-8	4 Tablets	2 Tablets	1 Tablet	
60-71	9-11		2 Tablets	1 Tablet	
72-95	9-11		3 Tablets	1 Tablet	
95 +	12 +		4 Tablets	2 Tablets	1 Tablet

STUDENT NAME _____ GRADE _____

Medication Name _____ Strength _____ mg
 Reason for Medication _____ Dose _____ tablet(s)
 Frequency or time of administration _____

Medication Name _____ Strength _____ mg
 Reason for Medication _____ Dose _____ tablet(s)
 Frequency or time of administration _____

Medication Name _____ Strength _____ mg
 Reason for Medication _____ Dose _____ tablet(s)
 Frequency or time of administration _____

Medication Name _____ Strength _____ mg
 Reason for Medication _____ Dose _____ tablet(s)
 Frequency or time of administration _____

I give my permission to the St. John's staff designated by the school to give the above stated medication(s) to my child according the instructions I have specified.

 Parent/Guardian signature

 Date

MEDICAL RELEASE FORM

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(One form per child)

Please complete this form and return on Registration Day. This is being done only in case of emergency and for legalities we may encounter for a student while they are under our supervision. Don't panic, this is only precautionary.

I give my permission for the responsible St. John's staff person and/or their designated person to obtain for my child medical and/or emergency treatment as deemed necessary.

Name of Child _____ Grade _____

Date of Birth _____

Child's Doctor _____ Doctor's Phone # _____

List here any special medical problems or medication your child is taking or allergic to.

Allergies Yes No (If yes, please note type of allergy & symptoms)

Medication Yes No (If yes, please list)

Medical Health History _____

Insurance Company Name and Subscriber Number _____

Parent/Guardian Signature

Home Telephone

Work/Cell Telephone

HEALTH INFORMATION

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Name _____

Grade _____

Your child's success in school, in part, depends on his/her physical well-being. The health information identified will be used as an aid to assist staff in educational planning. Please complete this form.

HEALTH CONCERNS If yes, please explain at the right	YES	NO	EXPLANATION
General health concerns			
Significant Hospitalization / Operations			
Physical Activity Limitations			
Significant Injuries			
Medication (name, time, why taken)			
Allergies (food, environment, animals)			
Vision (glasses, contacts)			
Hearing (hearing aid)			
Asthma			
On Asthma medication			
Diabetes			
Migraine Headaches			
Seizure Disorder			
Ear/Nose/Mouth/Throat Disorder			
Brain/Spinal Chord Disorder			
Heart/Circulatory Disorder			
Bone/Muscle Disorder			
Stomach/Bowel/Bladder Disorder			
Other Health Concerns			

Parent/Guardian Signature

Date