

## Saint Alphonsus School Health Program

Date: \_\_\_/\_\_\_/\_\_\_ School:  StPauls  StJoes  SMarks  SacredHeart  SMarys  BishopKelly  
Student: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
Parent: \_\_\_\_\_ Phone: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health History or Health Concern** (Please list any concerns that may affect your student during the school day (i.e. diabetes, seizures, ADD/ADHD, allergies, asthma, migraines, other conditions))

\_\_\_\_\_

\_\_\_\_\_

**Recent Immunization/Dates**

\_\_\_\_\_

### **Medication Policy**

Ideally, all medications should be given at home. However, there are situations where students may need medication during the day while attending school. It is important that this be done safely. This includes prescription as well as non-prescription medications.

- The school health nurse authorizes all medications administered at school. School personnel do not administer over the counter medication that has not been authorized.
- Students requiring medication at school will be identified to the school health nurse by the parent, or student him/herself
- Authorization forms are completed and signed by parent, school health nurse and student each school year.
- Unlicensed assistive personnel (e.g. school secretaries) may administer medication under the direction of the school health nurse, following appropriate training and instruction.
- Medications, including over the counter, will NOT be kept in lockers, desks etc
- Medications sent to school need to be in the original, current, properly labeled container.
- The school health nurse may contact the health care provider regarding medications or related health conditions.
- Under certain circumstances, students will be allowed to self-administer medications, but only with authorization by the school nurse.
- Students who need to carry an asthma inhaler will be identified to the school health nurse, and an "Agreement to Carry Inhaler" will be signed.

### **Authorization to give Medication (Prescription and OTC-Over The Counter)**

Medication/Dosage/Frequency \_\_\_\_\_  
Check all that apply: \_\_\_ Prescription \_\_\_ Non Prescription  
Medication given: \_\_\_ at home \_\_\_ at school  
Diagnosis/Reason for medication \_\_\_\_\_  
Special Instructions/Side effects \_\_\_\_\_  
Has student taken this medication before? \_\_\_ Yes \_\_\_ No

**I have read and understand the medication policy and authorize the above named medication(s) to be administered to my child. I understand that medication authorizations must be renewed each year.**

Parent signature \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

### **Authorization to give Acetaminophen(Tylenol) or Ibuprofen(Advil) ( Please check one box)**

I give my permission for the school nurse/authorized personnel, to give my child  Acetaminophen  Ibuprofen  no preference  NONE, at an age appropriate dose, at school, on an as needed basis, for minor aches and pains. I have read the school medication policy above and will comply with it. This authorization also must be renewed each school year. School personnel have permission to exchange information as needed.

Parent initial \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

