

Annual Health Update & Non-Prescription Medication Permission Form

Saint Joseph School - Brookfield, CT 06804

Pre K Program for school year _____

Please provide a separate form for each child

Student's Name _____ Grade _____ Teacher _____
DOB _____ Age _____

Updated student health history – please complete the following:

Yes ___ No ___ My child has the following allergies (environmental, food, insect ...): _____

Yes ___ No ___ I will provide an Epi Pen for in school allergic reactions. **Medical treatment orders required.**

Yes ___ No ___ I will provide Benadryl for allergic reactions. **OTC form required if not part of treatment orders.**

Yes ___ No ___ I will provide an inhaler for in-school use. **Medical authorization orders required.**

My child takes the following medications: _____

My child has the following medical condition(s): _____

Please call the school nurse if you wish to discuss any health issues regarding your child.

Below is a list of 2 medications that have been authorized by our school physician for administration by the school nurse with **written parental permission (your signature at bottom of page)**. Please indicate which of these medications you authorize the school nurse to administer to your child during school hours if needed.

Acetaminophen (generic Tylenol) Yes ___ No ___

Ibuprofen (generic Motrin, Advil) Yes ___ No ___

➤ I want to be notified every time the nurse administers medication to my child. Yes ___ No ___

First daytime phone number to call _____

Mother's Name _____ Father's Name _____

Mother's Home # _____ Father's Home # _____

Mother's Cell # _____ Father's Cell # _____

Mother's work# _____ Father's work # _____

Hospital of choice _____ Pediatrician _____ Phone # _____

In case of serious injury or illness at school, your child will be sent to an emergency medical facility. Parents/guardians will be contacted immediately and are responsible for all expenses.

Parent/Guardian Signature _____ Date _____