Otto-Eldred School District
Medical Information and Authorization for School Health Services

The following information is needed in order for the school nurse to give the most effective medical attention and treatment to your child. Please complete and return this form by the end of the first week of school.

Student's name: _____ Date of Birth: _____ Grade: ____

Medical conditions, mental/emotional conditions, physical limitations and recent surgeries:
_____
_____

Did your child sustain any type of head injury over the summer? ___No ___Yes, date _____

Does your child have a severe allergy? (Food, insect sting, medication, other) Please specify.
_____

What treatment is necessary? _____

Does your child require an Epi-pen or rescue inhaler during school? ___ Yes ___ No

List any daily medications taken; please give name, dose and frequency:
_____
_____
_____

Immunizations received this year and date (please provide copy for your child's record)
_____

In the case of an extreme emergency, and we are unable to contact you, your child will be transported to a nearby hospital. Please indicate Hospital preference.
_____

Physician's name: _____ Phone: _____
Dentist's name: _____ Date of last visit: _____

I give my permission to make the information on this form available to authorized school and transportation personnel if necessary. I also give permission to my child's health care provider/dentist to share any necessary information relating to my child's health with the school nurse.

Signature _____ Date: _____

(Please complete both sides)

PERMISSION TO GIVE OTC (over the counter) MEDICATION

Student Name _____ Grade _____

The following medications may be given on an as needed basis after assessment by the school nurse if there are no contraindications or allergies and with parental consent. Medications will be administered as directed by the manufacturer.
If you are able, please provide acetaminophen or ibuprofen in the original container with your child's name on it for their use.

Please draw a line through any of the following medications that you do NOT want used in the treatment of your child.

NON-ASPIRIN PAIN RELIEVER (Acetaminophen, Tylenol for pain or fever)

ANTI-INFLAMMATORY PAIN RELIEVER (Ibuprofen, Advil, Motrin for pain or fever)

ANTACID (Tums)

BENADRYL (diphenhydramine for allergic reactions)

THERA TEARS, EYE WASH OR CONTACT SOLUTION (minor eye irritations, contacts)

HYDROCORTISONE CREAM 1 % (for skin irritations or rashes)

COUGH DROP (for scratchy throat or cough)

CALADRYL CREAM (Minor skin irritations or rashes)

ANBESOL OR ORAGEL (toothache pain)

TRIPLE ANTIBIOTIC OINTMENT (minor cuts and wounds)

The school nurse may also use the following:

- Burn Gel for minor burns
- Vaseline for chapped lips.
- Ice pack for sprains and strains.

I authorize the use of the above medications, unless crossed out, for my child.

Signature: _____ Date: _____

(please complete both sides & return to the health office)
(revised 11/16/16)