Lipscomb Academy Middle/High School Health Form

Dear Parent:
In order for your child to be evaluated by the school nurse, should she/he become ill or experience some other type of health concern, your permission is required. By signing below, you have given the school permission to assist your child medically.

Student's name:_____ Grade_____

I give the school nurse permission to administer:
Yes___ No___ Acetaminophen (Tylenol) 160-650 mg – based on age/wt. (Given for pain, headache, fever)
Yes___ No___ Ibuprofen (Motrin, etc.) 100-400 mg – based on age/wt. (Given for pain, headache, fever)
Yes___ No___ Pamprin, Midol 1-2 caplets – based on wt./severity of pain (menstrual cramps)
Yes___ No___ Antacid tablets (Tums, etc)1-2 500mg tablets (for stomachache, indigestion)
Yes___ No___ Benadryl liquid or tablet 12.5 – 50mg (for sudden onset of allergic reactions)
Yes___ No___ Cough Drop 1 or 2 (for coughing, sore throat, nasal congestion)
Yes___ No___ Benadryl cream 1%, spray 2% (for itching due to insect bites and minor skin irritation)
Yes___ No___ Anti-bacterial Ointment (for cuts and abrasions, skin infections)
Yes___ No___ Caladryl/Calamine lotion (for itching due to poison ivy rash or minor skin irritation)
Yes___ No___ Hydrocortisone cream 1% (for itching due to minor skin irritation)
Yes___ No___ Aloe gel (for pain of minor burns or sunburn) May contain Lidocaine HCL
Yes___ No___ Insect bite swab contains Benzocaine and Menthol –for pain - 1 swab per sting/bite
Yes___ No___ Orajel (for gum pain, canker sores)
Any of the medications listed above may be generic brand.

Effective _____ until _____Date_____ FIRST DAY OF SCHOOL LAST DAY OF SCHOOL

Parent/Guardian Signature
_____phone_____

Health Care Provider's name
_____phone_____

PLEASE LIST ALL MEDICATIONS THE CHILD TAKES (home and school)
Name of Drug /Dosage Times taken _____
Purpose_____
_____
_____

Existing Medical Conditions_____
(Example: diabetes, seizure disorder, depression, chronic conditions)

Medication Allergies_____

Other Allergies_____

Yes___ **No**___ *I give the school nurse permission to notify my child's teachers of his/her* ***life-threatening*** *medical condition (i.e.* ***severe*** *allergic reaction, diabetes, and/or seizures).*

Please explain on back of form further details regarding this medical condition.

PERSONS TO CALL IF THE STUDENT IS SICK OR INJURED:

	(Name)	(Home)	(Work)	(pager or cell phone)
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Guardian	_____	_____	_____	_____

Insul_____ Aero_____ Topi_____ Behav_____ Anti_B_____ Seiz_____ Non-presc___ AAP on file____ DAAP on file___ Clinic use only