

McCann Vocational Technical High School
CONFIDENTIAL EMERGENCY HEALTH INFORMATION
From the Desk of the School Nurse

PLEASE COMPLETE FORM & RETURN IMMEDIATELY!

Name: _____ Birth date: _____ Sex: M/F
 (Last) (First) (MI) (circle)

School: _____ Grade: ____ Teacher: _____ School Year: ____

ALERT TO PARENTS: If your child has a serious medical condition, it is vital that you discuss this with your School Nurse and teacher(s) immediately. It is very important to know of **LIFE THREATENING** conditions.

In order to provide a safe and healthy environment for your child this information will be accessible to the following people: School Nurse, your child's teacher, office manager, personnel responsible for health room coverage and emergency medical personnel.

A. **Medical History**: Check the ones that apply to your child and describe under the comment section.

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Headaches	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Anxiety/Panic attack	<input type="checkbox"/> Hearing Problem	(explain)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> PE activity
<input type="checkbox"/> Bee sting allergy	<input type="checkbox"/> Kidney/urinary	Limited _____
<input type="checkbox"/> Bowel problem	problems	Not Limited _____
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Muscle Disorder	Explain: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neurological Concern	_____
<input type="checkbox"/> Color Blindness	<input type="checkbox"/> Orthopedic problem	_____
<input type="checkbox"/> Epi-Pen	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Emotional Concerns	<input type="checkbox"/> Vision problems	_____

Comments: _____

B. **ALLERGIES**: List allergies your child has that cause a problem at school.

Cause of allergy: _____ Treatment: _____

Cause of allergy: _____ Treatment: _____

C. **MEDICATION**: (Include prescription, over-the-counter and herbal medication.)

Name	Used to treat	Taken at school?	
1) _____	_____	Yes ___	No ___
2) _____	_____	Yes ___	No ___
3) _____	_____	Yes ___	No ___

Before medication of any kind can be administered at school, a medication administration form, available in the office, must be completed by parent and physician and kept on file.

D. Does your student wear contact lens? _____ Glasses? _____ Hearing Aid? _____

E. Name of Physician: _____ Phone: _____

Name of Dentist: _____ Phone: _____

F. Health Insurance: _____ (OVER)

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**MEDICATION ADMINISTRATION IN SCHOOL
PART A: Written Parent/Guardian consent
For acetaminophen or ibuprofen**

Student: _____
(Last) (First)

Parent/Guardian: _____
(Please print)

Address: _____

Tel. # (Home): _____ Tel #. (Work) _____

Cellular #: _____ Pager #: _____

Other person(s), if any, to be notified in case of emergency if parent/guardian is unavailable:
Name: _____ Tel #: _____

Relationship: _____

CONSENT

1. I give permission for the School Nurse or (school personnel designated by the School Nurse) to give my child (as listed above) the following medicine: acetaminophen 325 mg po, (generic Tylenol) or ibuprofen 200 mg po (generic Motrin), no more than once per day, up to two times each month for headache, (excluding head injury), menstrual cramps or pain per nursing assessment.

(Per standing orders of school physician. Please indicate a medication or dose preference if applicable).

2. I give permission to the School Nurse to share with appropriate school personnel (including teachers) information relevant to the prescribed medicine administration, e.g., adverse side effects, as determined necessary for my child's health and safety.

Yes _____ No _____ Any restrictions on release: _____.

PARENT/GUARDIAN SIGNATURE: X _____ **DATE:** _____

Relationship to student: _____