Health and Medication Form

Dear Parents,

Please read and sign **both forms** even if your child requires no medication. The completed and signed health forms are due to your child's teacher by **Friday, May 5th.** Please print clearly.

Health Information

Child's Name: ___________________________________ Date of Birth: ______________

School: ______________________ Homeroom Teacher's Name: _______________________________

- Does your child have any allergies? If yes, please explain. _______________________________________

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- Does your child have asthma? If yes, please describe symptoms, medication and treatment. ____________

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- Can your child participate in strenuous physical activities? If no, please explain. _____________________

____

- Does your child have any sleeping difficulties? If yes, please explain. ______________________________

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- Date of your child's last Tetanus booster. ____
- Does your child have any eating habits, food allergies or dietary needs? If yes, please explain. __________

____

- Is there any additional comments or information you feel would be helpful for us to know. _____________

____

Parent/Guardian Signature: ____________________________________ **Date:** _________

Over-the-Counter Medications Supplied by School

Please note that there are seven medications that will be provided by the school. These will be administered to your child, as needed, **if both you and your child's physician initial and sign, where required*** on form.

- Acetaminophen (Tylenol) for fever, pain: **Initials*** _____ _____
- Ibuprofen (Advil) for fever, pain: **Initials*** _____ _____
- Diphenhydramine (Benadryl) for allergic reactions, hives: **Initials*** _____ _____
- Children's Pepto-Bismol (no aspirin) for nausea heartburn, and diarrhea **Initials*** _____ _____
- Antibiotic Ointment (Bacitracin) for cuts: **Initials*** _____ _____
- Throat Lozenges **Initials*** _____ _____
- Calamine Lotion (topical) for insect bites **Initials*** _____ _____

Parent/Guardian Signature*: ____________________________________ **Date:** _________

Physician's Signature*: ____________________________________ **Date:** _________

Health and Medication Form (cont.)

Child's Name: ________________________________ School: ________________________

Homeroom Teacher's Name: ________________________________

Prescription & Over-the-Counter Medications

Please list any other medication below that your child might need on the trip. Prescription Medications must be in **Original Container with Original Prescription Label in English**. Over-the-counter must be in **Original Container with Child's Name on it.** **Do Not Mix Medications in the Same Container**. Please indicate if medication is a Daily or as needed (PRN) then **both you and your child's physician must sign, where required*** on form.

Name of Medication: ____

Dosage: ____________________ How to Administer: ________________________________

Time to Administer: ________________________________ daily or as needed: ____________________

Name of Medication: ____

Dosage: ____________________ How to Administer: ________________________________

Time to Administer: ________________________________ daily or as needed: ____________________

Name of Medication: ____

Dosage: ____________________ How to Administer: ________________________________

Time to Administer: ________________________________ daily or as needed: ____________________

Name of Medication: ____

Dosage: ____________________ How to Administer: ________________________________

Time to Administer: ________________________________ daily or as needed: ____________________

Name of Medication: ____

Dosage: ____________________ How to Administer: ________________________________

Time to Administer: ________________________________ daily or as needed: ____________________

Name of Medication: ____

Dosage: ____________________ How to Administer: ________________________________

Time to Administer: ________________________________ daily or as needed: ____________________

Parent/Guardian Signature*: ____________________________ **Date: _________**

Physician's Signature*: ________________________________ **Date: _________**