

SAINT JOSEPH SCHOOL BROOKFIELD, CT 06804

**ANNUAL HEALTH UPDATE/NON-PRESCRIPTION MEDICATION PERMISSION FORM
Pre - School 2011-2012**

Student's Name _____ Grade _____ Teacher _____

Dear Parent/ Guardian,

We would like to update your child's health history. Please complete the following:

- Yes ___ No ___ My child has allergies (food, insect, medication, etc.). List below
- Yes ___ No ___ I will provide an Epi Pen for in school allergic reactions. **Prescription medication form required**
- Yes ___ No ___ I will provide Benadryl for allergic reactions. **Over-the-counter medication form required**
- Yes ___ No ___ I will provide an inhaler for in-school use. **Inhaler and prescription medication forms required**
- Yes ___ No ___ My child takes the following medication (daily or occasionally). Please list.
- Yes ___ No ___ My child is covered under a Health Insurance Plan.

Yes ___ No ___ My child has the following specific allergy, illness or problem. Please explain.

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

Below is a list of the medications that have been authorized by the Brookfield, CT school physician for administration by the school nurse with **written parental permission**. Please indicate which of these medications you authorize the school nurse to administer to your child, if necessary.

I give the school nurse my permission to administer the following medication to my child during school hours. Please circle below Yes or No.

Saint Joseph School Brookfield, CT

Acetaminophen (Generic Tylenol)	Yes	No
Ibuprofen (Generic Motrin/Advil)	Yes	No

NO ___ YES ___ I want to be notified every time the school nurse administers medication to my child.

Mother's Name _____ Father's Name _____

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

Mother's Work # _____ Father's Work # _____

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

Hospital of choice _____ Personal Physician _____ Phone # _____

*In case of serious injury or illness at school, your child will be sent to an emergency medical facility.
The parent/guardian will be contacted immediately and is responsible for all expenses.*

Parent/Guardian Signature _____ Date _____