

**SAINT JOSEPH SCHOOL    BROOKFIELD, CT 06804**

**ANNUAL HEALTH UPDATE/NON-PRESCRIPTION MEDICATION PERMISSION FORM (2011-2012)**

*Please provide a separate form for each child*

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). *List below.*
- 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 Advil)	Yes	No
Antacid (Tums)	Yes	No
Cough drop	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 \_\_\_\_\_