Immunizations Received ☐ **Emergency Action Plan on File** ☐ **Medications Verified and Signed** ☐

GEIST
MONTESSORI ACADEMY

Allergies
_____
_____
_____
_____

Dose Calculation
AGE: _____
HEIGHT:_____
WEIGHT:_____LBS

Student Health Information Card

School Year 2020-2021

Student's Name: _____ **Date of Birth:** _____

Parent Contact Name: _____ **Parent Phone#:** _____

Additional Contact Name: _____ **Additional Phone#:**_____

Child's Pediatrician Name: _____ **Pediatrician Phone #:**_____

Child's Dentist Name: _____ **Dentist Phone #:**_____

Student Health History

If you answer yes to any of the following questions, please explain in the space provided.

Has your child ever been diagnosed with a medical condition? Yes (explain) or No

_____

Allergies (Environmental, Latex, or Food) Yes or No Type: _____

Is your child aware he/she has an allergy? Yes or No Can he/she self-manage this allergy? Yes or No

_____

Food Intolerance Yes or No _____

Asthma/Reactive Airway Disease Yes or No _____

Diabetes Yes or No _____

Seizure Disorder Yes or No _____

Emotional/Behavioral Concerns Yes or No _____

What medications is your child currently taking (prescribed or over the counter)?

_____

Does your child have a special IEP, 504 plan, or Individual Health plan? Yes or No

Additional Information for the School Nurse:

_____

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Clinic Visit Log and School Nurse Notes

Date	Notes

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Medication Orders

Prescription Medications

Defined as those medications that are to be given on a daily basis during the school day. These medications must be sent in the original prescription container with the original prescription label intact. The prescribing physician must sign this order in order for the school nurse to administer this medication to your child at school. Epi Pens, Inhalers/Nebulizers, Seizure medications and any daily prescription medication your child takes falls under this category and will need a physician's signature to be kept at school and administered.

Medication Name:

_____

Dosage:

_____

Route:

_____

Time to be Administered:

_____

Diagnosis Supporting Medication:

_____

Side Effects to be Expected: _____

Medication Name:

_____

Dosage:

_____

Route:

_____

Time to be Administered:

_____

Diagnosis Supporting Medication:

_____

Side Effects to be Expected: _____

Date: _____

Parent Name: _____

Parent Signature: _____

Physician Name: _____

Physician Signature: _____

Over the Counter Medications

During the school day, if your child should need an over the counter medication as listed below, the school nurse shall provide this for him or her. All over the counter medications are provided by the school in the school nurse clinic. No outside over the counter medications will be accepted, unless authorized by the school nurse and the child's individual parent and pediatrician, on a case by case basis.

Consent…

By initialing, you are authorizing the school nurse to give the following medications if the nursing assessment warrants medication to be given. If you prefer for your child not to have these, do not initial next to the item you do not want.

OTC Medication: **Consent:**

Tylenol (Acetaminophen) _____
For fever, headache, injury, pain, or per RN discretion
Preference of Type: Please Circle One Below
Tablets
Liquid Suspension
Pill

Advil (Ibuprofen) _____
For fever, headache, injury, pain, or per RN discretion
Preference of Type: Please Circle One Below
Tablets
Liquid Suspension
Pill

Benadryl Allergy _____
Preference: Please Circle One Below
Liquid Suspension
Pill

Cough Drops _____
Neosporin _____
Calamine Lotion _____
Vaseline _____
Sunscreen _____

*Any sunscreen you prefer your child to use at school must be sent in separately and will be housed in the child's classroom to be used for outdoor activities.

Additional Medication Instructions per Parent:

_____

_____

Parent Name: _____ **Date:** _____

Parent Signature: _____

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Medication Administration Record

Date	Time	Medication	Dose Given	Signature

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Medication Administration Record

Date	Time	Medication	Dose Given	Signature

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