**Nay Ah Shing Schools**

**Confidential Health Information Form**

**PRINT** Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_ M \_\_\_\_\_\_\_ F \_\_\_\_\_\_\_

School Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ New Student \_\_\_\_\_\_\_\_\_\_\_\_ Returning Student \_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Consent for Release of Information:**

The disclosure of health information within the school is limited to information necessary to serve the student’s health and education interests. Your *voluntary* agreement gives permission for school staff to inform select school personnel (teacher, bus driver, nutrition, etc.), of precautions and procedures necessary to protect your child at school as well as allows the school to exchange student personal information with the providers listed below.

◯ I AGREE ◯ I DISAGREE Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider and Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist and Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eyecare Provider and Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student wear glasses/contacts? \_\_\_\_\_\_ YES \_\_\_\_\_ NO

Does the student wear hearing aids? \_\_\_\_\_\_ YES \_\_\_\_\_ NO

Your student’s health history is important to provide the best care at school. It is the responsibility of the parent/guardian to notify the school of new or existing health concerns. If your student is prescribed medication or requires treatment at school, contact the school nurse and provide the medication or necessary equipment for use at school.

◯ My child has no special health concern and does not require medication and treatment while in school.

◯ YES, my child is diagnosed with a special health concern that may require routine or emergency medication and treatment while in school.

Check all that apply, and take the REQUIRED CARE PLAN to the medical provider to complete.

**Asthma:** Intermittent \_\_\_\_\_ Exercise Induced \_\_\_\_\_ Uses Inhaler \_\_\_\_\_

**Diabetes:** Type 1 \_\_\_\_\_\_\_\_ Type 2 \_\_\_\_\_\_\_\_\_\_\_\_\_ Pump/Insulin \_\_\_\_\_

Page 2

**Student Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History** (check all that apply)

\_\_\_\_\_ Asthma \_\_\_\_\_ Vision Problems \_\_\_\_\_ Kidney/Bladder Problems

\_\_\_\_\_ Diabetes \_\_\_\_\_ Hearing Problems \_\_\_\_\_ Bleeding Disorder

\_\_\_\_\_ Heart Condition \_\_\_\_\_ Dental Problems \_\_\_\_\_ Menstrual Problems

\_\_\_\_\_ Seizures/Epilepsy \_\_\_\_\_ Color Blindness \_\_\_\_\_ Eczema

\_\_\_\_\_ Depression \_\_\_\_\_ Frequent Nose Bleeds \_\_\_\_\_ Anorexia/Bulimia

\_\_\_\_\_ Hyperactivity \_\_\_\_\_ Frequent Stomach Aches \_\_\_\_\_ Mental Health Diagnosis

\_\_\_\_\_ ADD/ADHD \_\_\_\_\_ Frequent Headaches \_\_\_\_\_ Emotional/Behavioral Concerns

\_\_\_\_\_ FAS/FAE \_\_\_\_\_ Frequent Sore Throats \_\_\_\_\_ Physical Handicap

\_\_\_\_\_ Speech Problems \_\_\_\_\_ Orthopedic Conditions \_\_\_\_\_ Concussion

If you marked any of the above, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations**

For the protection of all students, Minnesota State Law (M.S. 123.70) requires that all children who are enrolled in school be vaccinated against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis B and varicella (Chicken Pox), allowing certain exemptions. Before students can attend school, each student must provide proof that the immunization schedule is in process or has been completed. Please include a copy of immunization records.

**Medical and Authorizations Release**

Authorization for emergency Medical Care and Medical Treatment. My child has permission to be administered minor first aid on school grounds during the school day by school personnel. In case a student becomes sick or injured during the school day, you will be notified. In the event that we are unable to reach you, we will attempt to contact persons listed as emergency contacts. If we can not contact you or the emergency contacts listed, we will be sure the student receives the needed medical attention. It is extremely important that you verify that we can take your child to the nearest hospital for medical attention. School personnel will accompany the student to the clinic until you or an emergency contact arrives. The school is in no way responsible for the medical bills incurred. I hereby authorize the medical providers at Ne-Ia-Shing Clinic or the nearest hospital to provide the necessary treatment to the student and release medical information as needed for insurance purposes.

\_\_\_\_\_\_\_\_\_Accept \_\_\_\_\_\_\_\_Decline \_\_\_\_\_\_\_\_\_Initials

**Medication Administration**

No medications, over-the-counter or prescribed, will be given to a student without proper written authorization. All medications taken during school hours must have a “Medication Administration Request” form completed and signed by parent/caregiver. For prescription medications, the form must be signed by parent/caregiver AND physician. All medication must be brought to the health office in its original container, labeled by a pharmacist in accordance with the law. Over-the-counter medications should be unopened and labeled with the student's name. All medication taken by students must be kept in the school nurse’s office. Certain emergency medications may be carried and administered by a student after doctor, parent and school nurse approval.



**Nay Ah Shing Schools**

|  |
| --- |
| **Medication Administration Request Form** |

**Please complete this form only if your child needs to have prescription based medication or over-the-counter medication administered during school hours.**

✔ Parent/Guardian(s) of student(s) requesting that prescription medication be administered during school hours are required to provide: ***physician's order (below), parental release and the medication supplied in its original container.***

✔ Any over-the-counter medication requested to be administered during school hours must be supplied by parent/guardian and provided to the school health staff labeled and in its original container with this form completed by parent/guardian. (Requires parent/guardian signature only)

✔ Orders must be updated yearly.

✔ Whenever possible medication should be given at home & every effort should be made to avoid school hours.

✔ Parent/Guardian(s) are responsible for notifying the school of a student's need for medication during school hours and informing the school of any changes to prescriptions throughout the school year.

✔ For the safety of your child and other students; ALL medication must be stored in the nurse's office and should not be carried by a student *except* for rescue medications with the nurse's approval.

✔ Dispensing of medications to students shall be done by authorized school personnel.

|  |
| --- |
| **Physician’s Order for Medication Administration** |

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication:** | **Strength:** | **Dose:** | **Time:** | **Reason:** | **Possible Side Effects:** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Name & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Parental Authorization for Medication Administration** |

I request this medication to be given as directed above. I understand the district is rendering a service and does not assume any responsibility for this matter. I release school personnel from liability in the event of any reactions resulting from this medication. If necessary the school may request additional information from the physician regarding this illness or medication.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nay Ah Shing Schools**

|  |
| --- |
| **OTC Medication Administration Request Form** |

**Complete this form for a child to have Over-the-Counter (OTC) medication administered during school hours.**

✔ Parent/Guardian(s) of student(s) requesting that Over-the-Counter (OTC) medications be administered during school hours are required to provide ***parental release and the medication supplied in its original container.***

✔ Any over-the-counter medication requested to be administered during school hours must be supplied by parent/guardian and provided to the school health staff labeled and in its original container with this form completed by parent/guardian.

✔ Orders must be updated yearly.

✔ Whenever possible medication should be given at home & every effort should be made to avoid school hours.

✔ Parent/Guardian(s) are responsible for notifying the school of a student's need for medication during school hours and informing the school of any changes to medications throughout the school year.

✔ For the safety of your child and other students; ALL medication must be stored in the nurse's office and should not be carried by a student *except* for rescue medications with the nurse's approval.

✔ Dispensing of medications to students shall be done by authorized school personnel.

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication:** | **Strength:** | **Dose:** | **Time:** | **Reason:** | **Possible Side Effects:** |
| acetaminophen | 160 or 325 mg | 1-2 tabs | As needed | Fever, pain, headache | N/A |
| ibuprofen | 200 mg | 1-2 tabs | As needed | Fever, pain, headache | Stomach discomfort, bleeding |
| aspirin | 81 mg | 1-4 tabs | As needed | Fever, pain, headache | Reye’s Syndrome, bleeding |
| Diphenhydramine (Benadryl) | 12.5 mg | 5-10 ml | As needed | Nasal congestion, hives | drowsiness |
| Benzocaine (oral pain relief gel) | 20% | varied | As needed | Tooth pain | N/A |
| Triple antibiotic cream and cleansers | N/A | varied | As needed | Prevent infection | N/A |
| First Aid and Burn Cream | 0.13%/0.5% | varied | As needed | Pain relief, prevent infection | N/A |
| Benadryl/anti-itch cream | 1% | varied | As needed | Alleviate itch, treat hives | N/A |
| Lotion, Blistex, Chapstick, petroleum | N/A | varied | As needed | Dry skin and lips | N/A |
| TUMS/antacid | 500-700 mg | 1-4 tabs | As needed | Indigestion, stomach ache | N/A |
| Cramp Tabs acetaminophen/pamabrom | 325mg/25mg | 1-2 tabs | As needed | Pain, fever, fluid reduction | N/A |
| Eye wash, saline | N/A | varied | As needed | Rinse eyes, provide moisture | N/A |
| Cough drops | N/A | 1-4 drops | As needed | Cough, sore throat | N/A |
|  |  |  |  |  |  |

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_