
I give permission to have the school nurse, or school personnel designated by the nurse, administer the following (please check):

- ...Acetaminophen (Tylenol) ...Benadryl (emergencies only) ...Ibuprofen (Advil)
...Calamine Lotion ...All of the above ...None of the above

Signature of Parent/Guardian _____ **Date** _____

ANNUAL STUDENT HEALTH SERVICES REPORT

Does student have any chronic health conditions? _____

Is student environmentally sensitive? _____

Does student have difficulty concentrating? _____

Names of medications taken on a regular or as needed basis at home, and reason taken:

Any additional information school should be aware of? _____

Restrictions: Classroom _____ Physical Education _____

Student is allergic to: _____

Are allergy injections being administered? ...Yes ...No

Vision: Known problem _____

...Glasses ...Worn constantly ...Other _____ ...Contact Lenses

Special seating needed? ...Yes ...No

Hearing: Known problem _____

...Frequent earaches ...Tubes

Special seating needed? ...Yes ...No

Any illnesses, injuries, or surgery since last school year? _____

I give permission to the school nurse to share this information with the appropriate school personnel.

Signature of Parent/Guardian _____ **Date** _____

Updated 5/03
/nurse00-01/forms.doc

Prescription Medication Form

HAMPDEN-WILBRAHAM REGIONAL SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

School _____

Student's Name _____ Sex _____ Date of Birth _____
Last First

Physician's Name _____ Address _____ Phone # _____

I request that my son/daughter be assisted in taking the medication(s) described below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below).

Signature Parent/Guardian

Home Phone

Emergency Phone

Date

The following is to be completed by the Physician:

Diagnosis for which medication is given: _____

Name of Medication: _____

Form: _____ Dosage: _____

If medication is to be given DAILY, at what time? _____

If medication is to be given "WHEN NEEDED", describe indications: _____

How soon can it be repeated? _____

Is student authorized to medicate herself/himself?YesNo

List significant side effects: _____

Date to start: _____ Date to stop: _____

Other information _____

Physician's Signature:

Date:

School Nurse's Signature: