

Western Line School District Non-Prescription Medication Administration 2020-2021

Student's Name: _____ Teacher: _____

Dear Parent or Guardian:

The Western Line School District has obtained standing orders from the District III State Health Officer/Physician for the school nurse to administer medications for minor conditions. No over-the-counter medicine will be given in the absence of the school nurse. **If you want your child to receive any over-the-counter medicine while at school, you will be required to complete the form below and provide that medicine in the original container labeled with the student's name. You must also provide a note stating what specific condition/complaint that medicine is to be used for.**

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I, _____, give permission for the school nurse to administer the medications as listed below to my child, _____, while at school. I understand that there is no liability on the part of the school district, its personnel, or the nursing staff of Western Line School District for civil damages as a result of the administration of this medication to my child.

Parent signature: _____ Date: _____

Please mark appropriately for each medication.

	YES	NO
Acetaminophen (Generic Tylenol)	_____	_____
Antifungal Cream	_____	_____
Caladryl or Hydrocortisone Cream	_____	_____
Benadryl Cream	_____	_____
First Aid Cream	_____	_____
Ibuprofen (based on weight)	_____	_____
Tums or Pepto Bismol	_____	_____
Orajel	_____	_____
Throat Lozenges/Cough Drops	_____	_____

.....
PLEASE COMPLETE THE BACK OF THIS FORM



WESTERN LINE SCHOOL DISTRICT STUDENT HEALTH INFORMATION 2020-2021

The information requested on this form will provide the school with essential information regarding your child’s health needs. This information is completely confidential; however, it may be shared with appropriate school personnel, only as necessary.

Student’s Full Name: _____ Date of Birth: _____
 Teacher’s Name: _____ Grade: _____
 Mother/Guardian: _____ Home#: _____ Cell/Work#: _____
 Father/Guardian: _____ Home#: _____ Cell/Work#: _____
 Emergency Contact #1: _____ Phone#: _____ Relationship: _____
 Emergency Contact #2: _____ Phone#: _____ Relationship: _____

CHECK THE APPROPRATE BOX IF YOUR CHILD HAS ANY MEDICAL CONDITION.

*****Only those conditions diagnosed by a doctor.**

NO MEDICAL CONCERNS AT THIS TIME

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Anaphylactic Allergy | <input type="checkbox"/> Bladder/Bowel Problems | <input type="checkbox"/> Insulin | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stinging Insect Allergy | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Insulin Pump | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Food Allergy _____ | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Asthma* |
| <input type="checkbox"/> Other Allergy _____ | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epi-Pen at School** | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Depression/Anxiety | |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hydrocephalic | |

Care Plans

The Western Line School district has healthcare management plans for the above medical concerns. Please contact the school nurse to request a health care plan for your child. Contact information is below.

Medications at School

A medication form is to be completed and returned before any medication can be administered in school. See Western Line School District Policy (Administration of Medications at School) for more information.

Asthma Self-Administration Form

*An Asthma Self-Administration Form is required if your student is to carry an inhaler at school. The form is available from the school nurse. The form must be completed and signed by your healthcare Provider annually.

Epi-Pen Self Administration Form

**An Epi-Pen Self-Administration Form is required to carry an Epi-Pen at school. The form is available from the school nurse. This form must be completed and signed by your Healthcare Provider annually.

List medications currently taking: _____

Parent/Guardian Signature: _____ Date: _____