

Annual Health Report Update

Westbrook Middle / High School Health Office

This form must be completed and forwarded to the health office

Student: _____ Grade: _____ Date: _____

Authorization to administer non-aspirin medication

1. I authorize the school nurse, with a standing order from the school medical advisor, to administer at her discretion the following medications to my child:

Acetaminophen (Tylenol) 325 mg each 1-2 tabs every 4-6 hours as needed for headaches or minor pain.

Parent Signature _____

Ibuprofen (Advil) 200 mg each 1-2 tabs every 4-6 hours as needed for muscle pain, menstrual cramps, and headaches. **Parent Signature** _____

Cetirizine HCl (Zyrtec) 10 mg each 1 tablet once a day for seasonal allergy symptoms such as sneezing, itchy eyes, or runny nose. **Parent Signature** _____

NOTE: If medication is to be given in school (other than Tylenol/Ibuprofen or Zyrtec), it must be accompanied by a signed AUTHORIZATION FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL form. Self administration is not permitted during the school day or field trip unless authorized by the MD, parent, and school nurse.

Annual Confidential Health Update

2. Is there any reason your child should not participate in certain activities or physical education? _____

If yes, reason: _____

3. My child is presently taking the following medication(s). Please include any daily medications.

_____ For _____

_____ For _____

Physician prescribing medication: _____

4. My child has the following medical condition(s):

Asthma _____ Diabetes _____ Heart _____ Vision _____ Cerebral Palsy _____ Epilepsy _____

Speech Defect _____ Psychological _____ ADHD _____ Hearing _____ Urinary _____ Other _____

Allergies (please check those that apply): Life threatening _____ Bee Sting _____

Peanuts/food _____ Environmental _____ Medication _____ Other _____

IF ANY ALLERGIES ARE CHECKED PLEASE COMPLETE ALLERGY TREATMENT PLAN. IF ASTHMA IS CHECKED PLEASE FORWARD ASTHMA PLAN.

5. My child has had the following serious accident(s), operation(s), illnesses or immunizations in the past year:

6. Is there anything you would like to discuss with the school nurse or student support team?

7. Is your child protected by health insurance? _____

Signature of Parent/Guardian: _____ Date: _____