Pierz Independent School District #484
Confidential Health Form 2018-19

Please **complete both sides** of this form and return as soon as possible to your child's school. All information is confidential, and shared only with those who work directly with your child. This information is important to best serve and care for your child.

Name:___________________________________ DOB: __________ Grade:________

Doctor/Clinic: _____________________________

Allergies: ____

Daily medications

Medication | Dose | Time of day:

1. ____
2. ____
3. ____

I have concerns about my child's:

□ Vision □ Hearing □ Weight (low | high)

Medical interventions needed at school:

Contacts	EpiPen	Glasses	Hearing aids (right | left | bilateral)
Inhaler	Nebulizer	Medication	Tube feeding

HIGH RISK HEALTH CONDITIONS:

□ **Asthma** □ **Bee Sting Allergy** □ **Food Allergy** □ **Diabetes** □ **Seizures/Epilepsy**

OTHER HEALTH CONDITIONS:

□No known health conditions
□ADD/ADHD
□ Anxiety
□Autoimmune disorder
□Autism
□ Behavior disorder
□Bowel or bladder disorder
□Blood pressure concern
□Concussion/Head injury (significant)
□Depression
□Developmental delay
□Emotional concern/disorder
□Genetic disorder
□ Other health condition(s): ____
□Hearing impairment
□Heart condition
□Kidney disorder
□Major surgery
□Neurological disorder
□Post traumatic stress disorder (PTSD)
□Seasonal Allergies
□Sensory processing disorder
□Skin condition
□Speech impairment
□Visual impairment

Please specify/describe any conditions selected above:

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OVER – SIGNATURE REQUIRED

OVER THE COUNTER (OTC) MEDICATIONS IN SCHOOL

1. _____I request the below named/selected FDA **approved** medication(s) to be kept in the school health office and administered to my child during the school day according to the package directions. Only appropriate weight based doses will be administered.

2. ____ I do not wish for my child to have OTC medications at school.

Medication	**Dosage**	**Time**
□ Ibuprofen	Per weight/ _______mg	Every 6 -8 hours as needed
□ Tylenol	Per weight/ _______mg	Every 4-6 hours as needed
□ Benadryl	Per weight/ _______mg	Every 4 -6 hours as needed
□ other: _______________	_____________________	_______________________
□ other: _______________	_____________________	_______________________

PARENT/GUARDIAN AUTHORIZATION

1. Medications must be supplied by the parent/guardian, in the ORIGINAL container and packaging.
2. Medication must NOT be expired.
3. Medications not meeting the above guidelines will not be administered, and will be returned.
4. Field trips – I give permission the medication to be administered on a field trip, as necessary, following school procedure, by trained district staff.
5. I release all school personnel, ISD 484, and any responsible adult administering the medication, from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication(s).
6. All medications will be sent home on the last day of school with the above named student. Remaining medications will be taken to the Pierz Police Department for disposal.
7. I understand that cough medications containing pseudoephedrine **will not be administered**.
8. I understand that my written permission must be on file before any OTC medication will be administered.

____ ______________________

Parent/Guardian Signature Date