Saint Joseph School
Wakefield Massachusetts

HEALTH INFORMATION and CONSENT
SCHOOL YEAR 2025 - 2026

THIS INFORMATION WILL BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL ON A NEED TO KNOW BASIS TO PROTECT THE WELL BEING AND SAFETY OF THE SUUDENT.

STUDENT NAME_____GRADE_____SEX □M □ F

STUDENT ADDRESS_____HOME PHONE_____

TOWN_____ZIP_____

DATE OF BIRTH_____BIRTHPLACE_____

MOTHER'S NAME_____ FATHER'S NAME_____

CELL PHONE_____ CELL PHONE_____

WORK PHONE_____ WORK PHONE_____

EMAIL_____ EMAIL_____

MILITARY FAMILY □ Y □ N

OTHER STUDENTS AT SAME ADDRESS_____

PRIMARY CARE PHYSICIAN_____PHONE_____

ADDRESS_____

DENTIST_____ PHONE_____

ADDRESS_____

HEALTH INSURANCE_____

EMERGENCY CONTACT 1

NAME_____RELATIONSHIP_____

HOME PHONE_____OTHER PHONE_____

EMERGENCY CONTACT 2

NAME_____RELATIONSHIP_____

HOME PHONE_____OTHER PHONE_____

HEALTH MODIFICATIONS

TO BE COMPLETED BY PARENT

PLEASE LIST ANY KNOWN MEDICAL CONDITIONS
□ GLASSES □ CONTACTS

_____

_____

_____

PLEASE LIST ANY FOOD OR DRUG ALLERGIES

_____

_____

_____

PLEASE LIST ALL MEDICATION STUDENT IS TAKING

_____

_____

_____

IN ORDER FOR MY STUDENT TO TAKE PRESCRIPTION MEDICATION AT SCHOOL THE ***MEDICATION ORDER FORM*** HAS BEEN COMPLETED BY THE PRIMARY CARE PHYSICIAN AND RETURNED TO THE SCHOOL NURSE.

SIGNATURE_____DATE_____
Parent/ Guardian

CONSENT

1. I give permission to have the school nurse give my child middle school child Tylenol or Ibuprofen according to age and weight for headache, fever, and minor aches and pains.
   YES_____NO_____

2. I give permission to have the school nurse give my child cough drops for cough.
   YES_____NO_____

3. I give permission to have the school nurse to apply topical lotions and cleansers such as bacitracin, betadine, hydrogen peroxide, hibiclens, calimine, caladryl, when administering basic first aid to my child. YES_____NO_____

FIELD TRIPS AND MEDICATION

I give permission to have school personnel designated by the school nurse give my child physician ordered medication during field trips. YES_____NO_____.

SIGNATURE_____DATE_____
Parent/ Guardian

MEDICATION ORDER FORM

TO BE COMPLETED BY PHYSICIAN ~ IF STUDENT TAKES PRESCRIPTON MEDICATION

NAME_____DOB_____

DIAGNOSIS FOR WHICH MEDICATION IS BEING PRESCRIBED: _____

_____

_____

MEDICATION: _____

_____

DOSAGE:

_____

_____

IS STUDENT AUTHORIZED TO MEDICATE HIMSELF/HERSELF_____

ALLERGY ACTION PLAN

ALLERGIC TO:_____

SYMPTOMS:_____

_____

(PLEASE NOTE PREVIOUS DOCUMENTATION OF MILD, MODERATE, SEVERE REACTION)

TREATMENT ~

ORAL MEDS _____

MED_____

DOSE _____

FREQUENCY _____

EPI PEN _____

DOSE _____

OTHER _____

_____ _____

PHYSICIAN SIGNATURE SCHOOL NURSE

_____ _____

DATE SIGNED DATE RECIEVED

It is understood that all medication will be supplied in the original labeled pharmacy container and that only those doses which shall be needed for school administration shall be included. Additionally, it is understood that any prescription medication should be delivered to the school by the student's parent/guardian. No student will be allowed to carry medication in school, without the express written authorization of the physician and in consult with the school nurse. It is understood to the extent possible, prescription medication required to be given to a student will be administered at home, either before or after school.