

Saint Joseph School  
Wakefield Massachusetts

**HEALTH INFORMATION and CONSENT**  
**SCHOOL YEAR 2019 - 2020**

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

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PLEASE LIST ANY FOOD OR DRUG ALLERGIES

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PLEASE LIST ALL MEDICATION STUDENT IS TAKING

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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 PRESCRIPTION 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 RECEIVED

*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.*