Sacred Heart School PS-Grade 8

Grade: _____ Date: _____

First Name: _____ Middle Name_____ Last Name_____

DOB: _____ Place of Birth: _____ Primary Language:_____

Physician's Name/Town:_____ Date of Last Physical:_____

Dentist's Name/Town: _____ Date of Last Dental Exam:_____

Current medications/dose @home. Y/N
@ School Y/N

Please list meds and doses:_____

_____

ALLERGIES Y/N

If Yes: Food _____ Medications _____ Insects _____ Environmental _____

Please list specific allergies:_____

_____

Life threatening allergies. Y/N
If Yes, does the student have an Epipen? _____
If Yes, can student administer to self? Y/N _____

Allergist's Name/Phone Number_____
Does student have asthma? Y/N
If Yes, does student have inhaler? Y/N
Can student carry/administer own inhaler? Y/N

Does student wear glasses/contacts? Y/N
If Yes, date of last eye exam _____
Does student have hearing issues? Y/N
If yes, please specify hearing issues: _____

Does student have other restrictions? Y/N
If yes, please specify_____

_____

Any significant illness,injuries or surgery in the last year? Y/N
If yes, please specify_____

_____

Student Health History

Has student ever had any of the following ?

Cardiac Disease	Y/N	Orthopedic Disorder	Y/N
Menstrual/Genitourinary Disorders	Y/N	Seizures	Y/N
Neurological Disorder	Y/N	Neurological Disorder	Y/N
Headaches/Migraines	Y/N	Headaches/Migraines	Y/N
Diabetes	Y/N	Sleep Disturbances	Y/N
Metabolic Disorder	Y/N	Blood Disorder	Y/N
Mononucleosis	Y/N	Hospitalizations/Surgery	Y/N
Psychological concerns	Y/N	Asthma/Resp Disorders	Y/N
Attention Deficit Disorder	Y/N	Cystic Fibrosis	Y/N
Eating Disorders	Y/N	Chronic Illness	Y/N
Anxiety Disorders	Y/N	Speech deficit	Y/N
Autism Spectrum Disorder	Y/N	Digestive disorders	Y/N
Meningitis	Y/N	Celiac Disease	Y/N
Kidney Disease	Y/N	Bowel problems	Y/N
Hernia	Y/N	Bladder problems	Y/N
Juvenile Rheumatoid Arthritis	Y/N	Nosebleeds	Y/N
Bone or Joint Problems	Y/N	Hx of concussion	Y/N
Eye concerns	Y/N	Hx of hearing deficits/loss	Y/N
Hx of frequent ear infections	Y/N		

If you answered YES to any of the above, please explain: _____

_____

_____

_____

_____

Special Education/Services	Y/N
Speech Language	Y/N
Special Diet	Y/N
Requires Specialized Healthcare	Y/N
Occupational Therapy	Y/N
Physical Therapy	Y/N
Counselor	Y/N

If you answered Yes to any of the above, please explain_____

_____

_____

If your child is eligible for the Covid-19 vaccine, has he/she been vaccinated Y/N

Sacred Heart School
Massachusetts State/School Policy
Regarding School Distribution of Medication

Please initial each item and sign below:

____ I give the school nurse permission to share the above confidential health information with staff directly working with my child/appropriate school personnel, along with my child's primary care physician, on an as needed basis in order to meet the health and safety needs of my child.

____ I give the school nurse permission to evaluate student illness or injury occurring during the school hours, and provide care as needed within the restrictions imposed by the standing orders authorized by the school physician.

____ I give the school nurse permission to administer the following medications: (check all that apply)

___Tylenol	___ Benadryl	___ Motrin
___ Neosporin Ointment	___ Hydrocortisone cream	___ Calamine Lotion
___ TUMS	___ Claritin	___ Epi-Pen 0.3mg IM for ages 6 to adult(greater that 70lbs) as needed For Anaphylactic emergency.

*All medication dosages are determined by weight
**Generic form may be substituted

Signature of Parent/Guardian: _____

Parent/Guardian Name (please print): _____

Parent/Guardian Phone Numbers Main:_____Cell:_____ Work:_____

Address:_____

Emergency Phone where parent/guardian can be reached at all times:_____

Emergency Contact(if/when parent/guardian is unavailable) _____

Phone Number 1:_____ Phone Number 2: _____

Relationship:_____

Sacred Heart School
Massachusetts State/School Policy
Regarding School Distribution of Medication

Policies have been established by the state of Massachusetts to ensure the health and safety of children needing medicines during the school day. *Every effort should be made to schedule medication outside of school hours.*

NOTE: COMPLETE ONLY IF OR WHEN YOUR CHILD NEEDS TO RECEIVE MEDICATION AT SCHOOL

Written Parent/Guardian Consent for prescribed Medication Administration

******All medications MUST be accompanied by a written order from the student's licensed prescriber (your child's physician, nurse practitioner, etc). This order must be renewed annually, or as needed.******

CONSENT FORM

1. I give permission to have the school nurse or personnel designated by the school nurse give the following medicine (exact name)_____ prescribed by (doctor or nurse practitioner) _____ to my child _____ during school hours.
2. I give permission for my child to self-administer medication if the school nurse determines it is safe and appropriate. Yes_____ No_____
3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as he/she has determined necessary for my child's health and safety. Yes_____No___

Medicines must be delivered to the school in a pharmacy or manufacturer-labeled container by the parent/guardian. Please ask your pharmacy to provide separate bottles /inhalers/epipens for school and home. No more than a 30 -day supply of the medicine should be delivered to school.

Signature of Parent/Guardian: _____

Relationship to student: _____

Date: _____