

Health and Medication Form

Dear Parents,

Please read and sign **both forms** even if your child requires no medication. The completed and signed health forms are due to your child's teacher by Friday, May 1st please print clearly.

Health Information

Child's Name: _____ Date of Birth: _____

School: _____ Homeroom Teacher's Name: _____

- Does your child have any allergies? If yes, please explain. _____

- Does your child have asthma? If yes, please describe symptoms, medication and treatment. _____

- Can your child participate in strenuous physical activities? If no, please explain. _____

- Does your child have any sleeping difficulties? If yes, please explain. _____

- Date of your child's last Tetanus booster. _____
- Does your child have any eating habits, food allergies or dietary needs? If yes, please explain. _____

- Is there any additional comments or information you feel would be helpful for us to know. _____

Parent/Guardian Signature: _____ **Date:** _____

Over-the-Counter Medications Supplied by School

Please note that there are seven medications that will be provided by the school. These will be administered to your child, as needed, ***But only if both you and your child's physician initial and sign, where required**** on form.

- Acetaminophen (Tylenol) for fever, pain: **Initials*** _____
- Ibuprofen (Advil) for fever, pain: **Initials*** _____
- Diphenhydramine (Benadryl) for allergic reactions, hives: **Initials*** _____
- Children's Pepto-Bismol (no aspirin) for nausea heartburn, and diarrhea **Initials*** _____
- Antibiotic Ointment (Bacitracin) for cuts: **Initials*** _____
- Throat Lozenges **Initials*** _____
- Calamine Lotion (topical) for insect bites **Initials*** _____

Parent/Guardian Signature*: _____ **Date:** _____

Physician's Signature*: _____ **Date:** _____

Health and Medication Form (cont.)

Child's Name: _____ School: _____

Homeroom Teacher's Name: _____

Prescription & Over-the-Counter Medications

Please list any other medication below that your child might need on the trip. Prescription Medications must be in **Original Container with Original Prescription Label in English**. Over-the-counter must be in **Original Container with Child's Name on it. Do Not Mix Medications in the Same Container**. Please indicate if medication is a Daily or as needed (PRN) then **both you and your child's physician must sign, where required*** on form.

Name of Medication: _____

Dosage: _____ How to Administer: _____

Time to Administer: _____ daily or as needed: _____

Name of Medication: _____

Dosage: _____ How to Administer: _____

Time to Administer: _____ daily or as needed: _____

Name of Medication: _____

Dosage: _____ How to Administer: _____

Time to Administer: _____ daily or as needed: _____

Name of Medication: _____

Dosage: _____ How to Administer: _____

Time to Administer: _____ daily or as needed: _____

Name of Medication: _____

Dosage: _____ How to Administer: _____

Time to Administer: _____ daily or as needed: _____

Name of Medication: _____

Dosage: _____ How to Administer: _____

Time to Administer: _____ daily or as needed: _____

Parent/Guardian Signature*: _____

Date: _____

Physician's Signature*: _____

Date: _____