ISD #484 Pierz Schools
Confidential Health Form 2022-23

Please **complete both sides** of this form and return it 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

HIGH-RISK HEALTH CONDITIONS:
☐ **Asthma** ☐ **Bee Sting Allergy** ☐**Food Allergy** ☐**Diabetes** ☐**Seizures/Epilepsy**

OTHER HEALTH CONDITIONS:
☐No known health conditions
☐ADD/ADHD ☐Allergy (Medication) ☐ Anxiety
☐Autism ☐Autoimmune disorder ☐ Behavior disorder
☐Bowel or bladder disorder ☐Depression ☐Developmental delay
☐Emotional concern/disorder ☐Genetic disorder ☐Head injury (significant)
☐Hearing impairment ☐Heart condition ☐Kidney disorder
☐Major surgery ☐Neurological disorder ☐Seasonal Allergies
☐Sensory processing disorder ☐Skin condition ☐Speech impairment
☐Visual impairment
☐ Other health condition(s): _____

Please specify/describe any conditions selected above:
_____

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

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

STUDENT OTC SELF CARRY AGREEMENT 7-12 GRADE ONLY

1. I understand that the ability to self-carry and self-administer my own OTC medication(s) is a privilege and not a right.
2. I agree to follow label instructions on the medication bottle(s) for how much and how often I can take this medication
3. I understand I am only allowed to carry Tylenol and Ibuprofen and those medications must be listed above.
4. I will report to the school nurse if my symptoms do not improve within ONE hour after taking medication, or if I am a experiencing side effects of the medication.
5. I WILL NOT share, borrow, or distribute these medications with another student, under any circumstance.
6. I understand that if I do not adhere to these requirements my privilege to self-carry and self-administer may be revoked.
7. I understand that ultimately the school nurse and building administration retain the final decision to allow me to carry and administer my own medication.

_____ _____

Student Signature Date