

Elko County School District Annual Student Health Update

Student Name: _____

Date: _____ Grade: _____ Sex: _____ Date of Birth: _____

MEDICATIONS

State law requires written authorization from a Healthcare Provider and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the nurse. All medication must be stored in the school health office.

Students are permitted to hand-carry prescribed emergency medications, such as an inhaler, an Epi-pen or diabetic supplies when the required forms are completed by the student's health care provider and parent/guardian. Such forms are available from the nurse.

Medication needed at school:

Medication needed at home:

AUTHORIZATION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS

ECSD Nurses are authorized to give Acetaminophen (Tylenol) and Ibuprofen (Advil) for minor illness. Before giving your student any medications, the nurse checks your student's medical history for conditions, allergies and any other medications your student is taking to make sure there is no conflict. You will always be notified immediately of any serious illness or injury.

Please notify the School Nurse if your child receives any medication before arriving at school.

Acetaminophen	5-11 Years Old	325 mg (one tablet) orally, every 4-6 hours as needed.
	12+ Years Old	325 mg (one – two tablets) orally every 4-6 hours as needed.
Ibuprofen	<12 years and weight is >44 lbs	200 mg (one tablet) orally every 4-6 hours as needed
	12+ Years Old	200 mg (one – two tablets) orally every 4-6 hours as needed.

Please Check Only ONE:

I give ECSD nurses permission to administer the above medications in the doses specified.

OR

I give ECSD nurses permission to administer these medications to my child, but only if I am contacted first.

OR

I do NOT give permission for any of the above over-the-counter medications to be given to my child.

In case of medical emergency, I authorize the school to seek medical attention for my child if, in the judgment of the school authorities medical treatment is necessary.

Parent/Guardian Signature

Date

DISCLOSURE OF HEALTH INFORMATION / MEDICAL EMERGENCIES

The disclosure of health information within the school is limited to information necessary to serve the student's health and education interests.

In the case of a medical emergency school personnel will make every attempt to contact the parents. The information contained in this form will be shared with emergency personnel.

SCHOOL HEALTH SCREENINGS

Vision, hearing, dental and scoliosis screenings as well as height and weight measurements are provided to students in various grades. Parents must provide a written statement to the nurse annually to excuse their child from mandated screenings.

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It is the responsibility of the parent/guardian to notify the school if there is a new or existing health condition which affects a student's ability to participate in school activities.

YES	NO	HEALTH CONDITIONS
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: Foods (Please list): Please Specify: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Life Threatening (requires epinephrine) Epi-Pen Prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> <input type="checkbox"/> School will be provided with Epi-Pen <input type="checkbox"/> Epi-pen will be carried by student <i>To ensure safe and appropriate care, all students with Life Threatening Allergies should have an <u>Allergy Management Plan</u> completed by the physician and parent/guardian. Please request the form from your School Nurse.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: <input type="checkbox"/> Bee <input type="checkbox"/> Other: Please Specify: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Life Threatening (requires epinephrine) Epi-Pen Prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes:</i> <input type="checkbox"/> School will be provided with Epi-Pen <input type="checkbox"/> Epi-pen will be carried by student <i>To ensure safe and appropriate care, all students with Life Threatening Allergies should have an <u>Allergy Management Plan</u> completed by the physician and parent/guardian. Please request the form from your School Nurse.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Allergies: Drug (Please list):
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (Please Specify): <input type="checkbox"/> Mild Intermittent (takes medication only with symptoms and symptoms occur 2 or fewer days/week) <input type="checkbox"/> School will be provided with inhaler <input type="checkbox"/> Student will carry an inhaler <input type="checkbox"/> Mild Persistent (takes medication only with symptoms and symptoms occur more than 2 days/week but less than daily) <input type="checkbox"/> School will be provided with inhaler <input type="checkbox"/> Student will carry an inhaler <input type="checkbox"/> Moderate (usually takes 1-2 medications per day to prevent symptoms and symptoms occur daily) <input type="checkbox"/> School will be provided with inhaler <input type="checkbox"/> Student will carry an inhaler <input type="checkbox"/> Severe (usually takes 2-3 long-acting medications per day to prevent symptoms) <input type="checkbox"/> School will be provided with inhaler <input type="checkbox"/> Student will carry an inhaler <i>To ensure safe and appropriate care, all students with inhalers should have an <u>Asthma Management Plan</u> completed by the physician and parent/guardian. Please request the form from your School Nurse.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <i>To ensure safe and appropriate care, all students with diabetes should have a <u>Diabetes Management Plan</u> completed by the physician and parent. Please request form from your School Nurse.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment or Complete Loss
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition (Please Specify):
<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Bone/Joint Problems (Please Specify):
<input type="checkbox"/>	<input type="checkbox"/>	Is student receiving care from a physician or other healthcare provider for migraines?
<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorder? (Please Specify):
<input type="checkbox"/>	<input type="checkbox"/>	Psychological/Emotional/Behavioral Issues (Please Specify):
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder: (Please specify type of seizure and date of last seizure or frequency of seizures)
<input type="checkbox"/>	<input type="checkbox"/>	Does student have any other health problems/conditions that may affect classroom performance or PE Activities? If so, please explain: