

# LEMPSTER COMMUNITY SCHOOL EMERGENCY/MEDICAL INFORMATION

Student: \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address(if different from above) \_\_\_\_\_

Student resides with: (Circle) Parent          Mother          Father          Guardian

Mother \_\_\_\_\_ Email: \_\_\_\_\_

Best number to reach you during the school day: \_\_\_\_\_

Father \_\_\_\_\_ Email: \_\_\_\_\_

Best number to reach you during the school day: \_\_\_\_\_

Step Parent/Guardian \_\_\_\_\_ Email: \_\_\_\_\_

Best number to reach you during the school day: \_\_\_\_\_

In case of emergency, illness or accident to the student: Names of people who may be contacted to assume responsibility for further action in case the school cannot reach parent or guardian.

1. \_\_\_\_\_ Daytime phone: \_\_\_\_\_

2. \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Does your child HAVE?

Asthma           Yes     No    Inhaler     Yes          ADHD/ADD           Yes     No

Seizures           Yes     No          Behavioral Concerns           Yes     No

Diabetes           Yes     No          Toileting Issues           Yes     No

Heart condition     Yes     No          Other: please explain           Yes     No

Please explain any conditions with a yes: \_\_\_\_\_

Is the student on daily medication? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If yes, list medication dose and time taken: \_\_\_\_\_

Hearing or vision problems? \_\_\_\_\_ (Glasses, contacts, hearing aids)

List known allergies: (medications, food, insects, environment) \_\_\_\_\_

Allergy symptoms or reactions: \_\_\_\_\_

Allergy medication taken: \_\_\_\_\_ Requires an EpiPen     Yes     No

Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Dentist \_\_\_\_\_ Phone \_\_\_\_\_

## OVER THE COUNTER MEDICATIONS--NO MEDICATION CAN BE GIVEN WITHOUT THIS PERMISSION

Please check off which medications can be dispensed to your child in the nurse's office.

Cough drop \_\_\_\_\_ Calamine Lotion \_\_\_\_\_ Antacid Tablets \_\_\_\_\_ Benadryl \_\_\_\_\_

Bacitracin Ointment \_\_\_\_\_ Ibuprofen \_\_\_\_\_ Acetaminophen \_\_\_\_\_ Hydrocortisone Cream \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Fill out other Side**

## LEMPSTER COMMUNITY SCHOOL EMERGENCY/MEDICAL INFORMATION

Should the need arise, may the nurse contact your physician to discuss your child's medication, immunizations, or health issues?( **circle one**) **Yes No**

Lions Club vision screening to be performed annually with school nurse following NH State requirements. Lions Club test consist of an instant scan (like a photograph) of your child's eyes to determine the possible presence of eye disorders. No physical contact is made with your child and eye drops are not used. The child simply looks at some blinking lights for about a second. I give my permission. **(circle one) Yes No**

Permission is hereby given to Lempster Community School to proceed with any necessary and prudent first aid for the protection and health of my child. In the event of serious illness or injury, I give permission to Lempster Community School to transport my child via ambulance to the nearest hospital and release pertinent information. I understand that every reasonable attempt will be made to contact me.

**(circle one) Yes NO**

### **Over The counter Medication**

Over the counter medications brought in for you child must be in their original container with a note from the parent, phone call or discussion with the nurse. Per NH law, students are not allowed to carry medications, except for those requiring an Epi-pen or inhaler with a physician order (this is an annual requirement).

### **Prescription Medication**

If your child needs to have prescription medication given during school, a dated doctor's order with MD/ARNP signature is required annually. Please request a prescription medication authorization form from the school or print one off from the school website.

I understand it is my responsibility to inform the school nurse should there be a change in my child's medical status or development of an allergy. I also understand that for the health and safety of my child, the school nurse may need to share pertinent medical information on a need-to-know with appropriate school personnel as per FERPA dictates.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Please Fill out other Side**