St. Michael's Country Day School

2021/2022
Annual Student Health History

REQUIRED INFORMATION. COMPLETE IN FULL.

Student's Name:_____ Date of Birth_____Grade_____

Address_____

Parent Contact #1:_____

Name Relationship to student Best phone #

Parent Contact #2: _____

Name Relationship to student Best phone #

Emergency Contact:_____

Name Relationship to student Best phone #

Check current or past Health Conditions:

Asthma____ Heart Conditions____ Bone or Joint Problems____ Anxiety___ Seizures___ Headaches___ ADHD___ Depression___ Diabetes___ Scoliosis___ Physical disability___ TB___ Eczema___ Bleeding Disorder___ Nose bleeds___ Strep throat___ Hives___Chicken pox____(must be documented by physician) Pneumonia___ Lyme Disease___ Concussion____ Earaches/infections___ Broken bones, if yes, which bones and year_____Operations _____

Please provide any additional information or condition/injury not mentioned above: _____

_____

MEDICATIONS

Does your child currently take medication, including inhalers, at home? Yes___ No___

Please list medications and reason for taking_____

Is there any medication that needs to be taken at school? Yes___ No___ If yes, please contact the school nurse.

MEDICATIONS IN SCHOOL must be administered by a nurse (no lay person other than a student's parent/guardian may give medication in school) in accordance with physician orders and signed parent/guardian consent. No child should bring medication to school. Emergency medications such as Epi pens, inhalers, glucagon and insulin, are exceptions to this rule and may be student carried and self administered, if physician approved, ordered, and in the Action Plan. Lay staff are trained to assist with emergency medications in accordance with state regulations.

ALLERGIES

Please list any ***known allergies, severity of reaction, and required treatments*** (including bee/insect stings, medications, environmental irritants, foods, etc.): _____

All severe allergic reactions requiring Epinephrine will need an Emergency Health Care Plan and medication at school, please contact RN.

DIET: Does your child have any non-allergy dietary restrictions? Please list_____

VISION: Does your child have any difficulty seeing?_____ Wears glasses_____ Wears contacts_____ Date of last eye exam_____
HEARING: Does your child have any difficulty hearing? _____ Tubes or hearing aides?_____ Date tubes placed_____

DENTAL: RI state law mandates that all elementary students be examined by a dentist at least once per year, or evaluated by the school dentist. Please provide the name of your child's dentist:_____ date of most recent dental exam:_____
PEDIATRICIAN: Name_____ Phone_____ date of most recent physical:_____

Parent/Guardian Signature_____ Date_____

School Nurse: Megan Buchanan RN, BSN (401) 849-5970 ext. 389 mbuchanan@smcds.org Revised 3/2021

Acetaminophen (TYLENOL) and Ibuprofen (ADVIL, MOTRIN) Permission Form

Student Name: _____ Date of Birth:_____

Per standing orders from our school physician, Dr. Catherine Labiak-Maher, the school nurse is able to give Acetaminophen and/or Ibuprofen up to 10 times in the school year, as needed, with your signed permission below.

More than 10 doses of Acetaminophen, or Ibuprofen, and **ANY** other medications, prescription or over-the-counter, must be accompanied by your child's physician's signed order, prior to medication administration. **The school nurse is not able to give antihistamines, cough medicine, allergy medications, etc. –even over the counter- without your doctor's signed orders.** Whenever possible, it is best to provide medications to your child before and after school hours.

I give my permission for the school nurse to administer the following medications, as indicated with a check mark below, up to 10 times each, as needed, for illness or injury during the 2021-2022 school year:

- ❑ **Acetaminophen (Tylenol)** (pain reliever, fever reducer)
- ❑ **Ibuprofen (Advil, Motrin)** (anti-inflammatory, pain reliever, fever reducer)

- ❑ DO NOT GIVE ACETAMINOPHEN OR IBUPROFEN to my child.

If either or both of the medications indicated above are allowed, please check your administration/communication preference below. As noted, RN attempts to communicate with parent/guardian prior to any administration of Tylenol or Ibuprofen.

- ❑ Wait to administer the above allowed medication, ***for my verbal consent, in addition to this signed form.***

- ❑ Yes, administer the above indicated medications for headache, pain/discomfort, or inflammation, as needed, even if unable to reach me by phone ahead of time. Contact me with complete details: reason given, medication, dose, form, and time, as soon as possible.

Parent/Guardian _____ Date:_____
(Print) (Signature)

Acetaminophen: 1 2 3 4 5 6 7 8 9 10 Ibuprofen: 1 2 3 4 5 6 7 8 9 10

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