DERBY HIGH SCHOOL 2020-2021
Nurse Emergency Medical Form and OTC Medication Authorization
Confidential

_____ _____ _____
Student Name Male/Female Grade

_____ _____
Home Address Date of Birth

Parent/Guardian Info: Name _____
Cell Number: _____ Work Number: _____ Home Number: _____

Parent/Guardian Info: Name _____
Cell Number: _____ Work Number: _____ Home Number: _____

In case of illness or accident during school hours, and a parent or guardian cannot be reached, please indicate below a person who may be contacted and/or transport your child.

Emergency Contact: _____ Number: _____

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Health Information (Use back side of this form if additional info is to be provided to the nurse)
*History of Asthma? Y N Medication: Y N Triggers: _____
_____

*Allergies? (meds, food, environment) Y N Is EPIPEN Required? Y N
*Specific Allergy: _____

*Medical/Mental Health Conditions: _____

*Surgeries/Hospitalizations: Date and Procedure _____
_____

*Medications taken at Home: _____
*Medications at School (MD order must be provided): _____

*Any physical limitations or restrictions for activity? (MD note must be provided) _____
_____
Physician: _____ Phone Number: _____

Does your child have health insurance? Y N Type: _____

I authorize the school nurse at Derby High School to administer the following medications to my child on an as needed basis, after my child has been assessed by the nurse. These medications will be given per package directions. They have been approved by the Derby Public Schools Medical Advisor (CT Public Act No 212A revised #88-360)

Check ALL that apply: (if it is not checked, nurse cannot give without parent permission)

_____Tylenol/Acetaminophen 650 mg by mouth, once per day

_____Ibuprofen/Motrin/Advil 400 mg by mouth, once per day

_____Tums/Antacids 2 tabs by mouth, every 4 hours as needed

_____Bacitracin Antibiotic Ointment as needed

_____ _____
Signature of Parent/Guardian Date