DERBY HIGH SCHOOL – 2017/2018
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: ___________________

Emergency Contact: ______________________ Number: ___________________

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