**This side of the form is REQUIRED to be filled out!

MT. PLEASANT SCHOOL DISTRICT HEALTH UPDATE

2019 - 2020

Name of Student_____Grade____Building_____

The following information is needed to plan an appropriate program for your child and to be prepared for any emergency situation should one arise. This confidential information will be shared with school staff on a "need to know basis".

MEDICAL HISTORY (check the ones that apply to your current health)

_____ADHD: Medication_____Time taken at home_____Time taken at school_____
_____Asthma
_____Hay Fever
_____Dental Problems: Orthodontic Braces_____Other_____
_____Diabetes
_____Depression
_____Hearing Problems
_____Heart Condition (specify)_____
_____Hemophilia
_____Physical Handicap (specify)_____
_____Seizures
_____Allergies (specify)_____
_____Other (specify)_____

LIST MEDICATION NEEDED FOR ASTHMA_____

Do you use an inhaler at school? YES_____ NO_____

Name of inhaler(s)_____

LIST MEDICATIONS TAKEN AT HOME OR SCHOOL_____

FOR WHAT MEDICAL CONDITION IS THE MEDICATION TAKEN?_____

_____

LIST OPERATIONS SINCE BEGINNING OF LAST SCHOOL YEAR_____

_____

LIST ANY INJURIES OR BROKEN BONES EXPERIENCED SINCE BEGINNING OF LAST SCHOOL YEAR AND DATE_____

DO YOU WEAR CONTACT LENSES? YES_____ NO_____ GLASSES? YES_____NO_____

LAST EYE EXAMINATION (Date)_____ Doctor_____

LAST DENTAL EXAMINATION (Date)_____Dentist_____

Please see reverse side for medication administration information and Medication Permission Form. Physician and parent/legal guardian signatures are required for prescription medications (including Inhalers and Epi-Pens). Only parent/legal guardian signatures are required for non-prescription medications (Tylenol, Ibuprofen, etc). ***All medication must be supplied to the school by the parent/legal guardian in the original/current container.***

Insurance Provider (Select One):

_____ **Private Insurance**
_____ **Medicaid (Title 19)**
_____ **Hawk-I**
_____ **None**

MT. PLEASANT COMMUNITY SCHOOL
MEDICATION PERMISSION FORM

According to School Board Policy, 504.4 Administration of Medication at School: "Written and signed authorization from the prescribing medical practitioner is required for all prescription medications and must include the name of the student, name of the medication, the dose of the medication to be administered, the time of day to be administered, and the indication for the medication."

"Written and signed authorization from the parent is required for all prescription and non-prescription medications and must include the name of the student, name of medication, dose to be administered, time of day to be administered and the indication for the medication to be administered."

"All prescription medications must be brought to the school by the parent in the original bottle from the pharmacy with the name of the student, name of medication, dose of medication, time of day to be administered and route of administration written on label. All non-prescription medications must be brought to school in the original container by the parent."

The time of medication administration may need to be altered slightly to fit your child's schedule. Please remind your child that she/he is responsible to go to the nurse's office at the appropriate time.

The bottom part of this form must be completed and returned to the school clinic in order for medication to be administered to your child at school.

Name of Student: _____ Grade_____

Name of Medication_____. This medication has been prescribed by

(Physician's Signature) _____ to be given during school hours.

Dosage: _____

Length of time medication is to be given (if known) is: _____

Time to be given at school: _____

_____

Reason for medication being given at school: _____

_____

The school district has my permission to contact the prescribing doctor if clarification is needed about this medication given at school.

_____ _____

Parent's Signature Date