The Academy for Classical Education

NURSE CONSENT FOR CLINIC SERVICES

Student Name: _____ Grade: _____ HR teacher: _____
Age: _____ Birthday ____/_____/_____ Sex: (Circle) M F

CONTACT INFORMATION: ***INCLUDE YOURSELF IN THIS LIST***

CONTACT PERSON	RELATION	HOME PHONE	WORK PHONE	CELL PHONE
1.				
2.				
3.				

HEALTH HISTORY: **(Include name of medicine, treatment, etc).**
Allergies (Specify type-food, medicine, bees/ants)_____
My child's allergy is life-threatening and he/she carries an Epipen (circle) YES NO

Asthma (circle) Yes No Medicine _____

ADHD/Other (circle) Yes No Medicine_____

Diabetes (Circle) Type I Type II Medicine _____

Sickle Cell (circle) Yes No Medicine_____

Seizures (circle) Yes No Medicine _____
My child has been prescribed Diastat (circle) YES NO

Any Other Health concerns: _____

Student's Doctor: _____ Phone: _____

A SCHOOL MANAGEMENT/ACTION PLAN OR AUTHORIZATION FOR MEDICINE ADMINISTRATION AT SCHOOL MAY BE NEEDED FOR HEALTH CONDITIONS.
*****Does your child need to carry anything such as Diastat, Epi-pen, Inhaler or Diabetic supplies while at school? If so, Please contact the nurse ASAP to set this up *****

MEDICATION INFORMATION:
My child takes the following medication at home daily: _____
My child takes the following medication at home occasionally/as needed:_____

Listed below are medications stocked in the Nurse's clinic (**we do not have cold or allergy medicine**). **No medication will be administered without consent.** ***Please check all medications your child may receive while at school.***

_____Tylenol (Acetaminophen) ____Advil (Ibuprofen**)** _____Antacids **(**Maalox/Tums) _____Benadryl
The products listed here are used unless the parent/guardian states **in writing not to use them: eye drops, antibiotic ointment, anti-fungal cream, anti-itching cream, peroxide, vaseline, cough drops, throat lozenges/spray.

I understand I can revoke this permission form by written notice to the school nurse.Parent/ Legal Guardian signature _____ Date_____