WELLINGTON-NAPOLEON R-9 SCHOOL DISTRICT
MEDICATION CONSENT & HEALTH HISTORY FORM

Student Name _____ DOB _____ Male ☐ Female ☐ Grade _____

The following is a list of over the counter medications that can be administered during school. Please initial on the line in front of the medication name that you wish for your child to receive while at school. Your child will not be given any of these medications without signed consent. Parents will be notified in writing when medication(s) are administered.

_____ Jr. Acetaminophen (generic Tylenol) 80mg. chewable tablet as directed on label for pain or fever.
_____ Jr. Ibuprofen (generic Motrin/Advil) 100mg. tablet as directed on label for pain or fever.
_____ Equate Antacid tablets (generic Tums) as directed on label for heartburn, sour stomach or upset stomach.

I give permission for the School Nurse or her designated substitute to administer the above initialed medications to my child as needed.

The School Nurse or her designated substitute will evaluate each request from the above listed medications and will administer only when appropriate. Any frequent request for a continuing condition will be discussed with the parents.

This permission may be terminated at any time by WRITTEN notification to the School Nurse.

Parent/Guardian Signature:_____ Date:_____

First aid treatments (check the ones that you consent to your child receiving if needed):

☐ Hydrogen peroxide	☐ Hydrocortisone cream 1%	☐ Burn Cream/Aloe
☐ Triple antibiotic ointment	☐ Benadryl cream	☐ Allergy eye drops
☐ Wound cleanser/Bactine	☐ Calamine lotion	☐ Muscle rub

Parent/Guardian Signature: _____ Date:_____

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Student Name _____ DOB _____

MEDICAL HISTORY

Has your child ever been diagnosed or treated for any of the following?			If Yes, please explain. Is this a current issue? Does your child see a doctor for this condition?
Diabetes** Type 1☐ Type 2☐	YES	NO	
Thyroid Disease	YES	NO	
Asthma**	YES	NO	Actively uses inhaler: Yes☐ No☐ As Needed☐
Heart or Cardiovascular Conditions	YES	NO	
Stomach Disorders	YES	NO	Acid reflux☐ Heart burn☐ Ulcers☐ Other_____
Intestinal Disorders	YES	NO	Chronic constipation☐ IBS☐ Other_____
Headaches	YES	NO	
Migraines	YES	NO	
Seizures**	YES	NO	Type:_____ Date of last seizure:_____ Currently under Doctor's care due to seizures: Yes☐ No☐
Kidney Disease	YES	NO	
Depression	YES	NO	
Anxiety and/or Panic attacks	YES	NO	
Mental Health Diagnosis	YES	NO	
ADD/ADHD	YES	NO	
Autism	YES	NO	
Vision problem/condition	YES	NO	Wears glasses☐ Wears contacts☐
Hearing problem/condition	YES	NO	Tubes☐ Other:
Neuromuscular Disorder	YES	NO	
Cancer	YES	NO	
Genetic Disorder	YES	NO	
Other medical condition(s):	YES	NO	

****Diabetes, Asthma, Seizures, and Anaphylactic allergies must have emergency action plans from their doctor on file.**

ALLERGIES

☐ YES (provide details below) ☐ No Known Allergies

Allergen	Specify Name/Type	Reaction	Treatment
Food			
Medication			
Stinging Insect			
Environmental			
Animal			

Please continue to page 3

CURRENT HOME MEDICATIONS/VITAMINS

MEDICATION	REASON FOR TAKING	DOSAGE	HOW OFTEN/TIME

PRESCRIBED MEDICATIONS TO BE GIVEN AT SCHOOL (*CONSENT FORM MUST BE SIGNED)

MEDICATION	REASON FOR TAKING	DOSAGE	HOW OFTEN/TIME

***CONSENT FORMS MUST ALSO BE SIGNED FOR SELF CARRY MEDICATIONS (EPI PENS, INHALERS)**

INSURANCE

Is your child covered by Health Insurance? YES NO HMO/Managed Care YES NO
Is your child enrolled in the Medicaid Program? YES NO UNSURE

Last physical exam _____ Healthcare Provider _____
Last dental exam _____ Dental Provider _____
Last vision exam _____ Vision Specialist _____

****Emergency action plans, self carry medication forms, and medication consent forms can be found on the school website.****

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MEDICATION CONSENT & HEALTH HISTORY FORM

Student Name _____ DOB _____

SCHOOL MEDICATION POLICY

Student medications should be given at home if possible. This decreases the chance of errors such as missed or forgotten doses. Medications will only be given during school hours by complying with these guidelines:

1. Medication consent and health history form is completed and signed.
2. Parents/Guardians must sign-in prescription medication and over-the-counter (OTC) medication (other than those listed on Medication Consent Form), at the nurses office. Students are not allowed to bring medications with them to school.
3. Medications will only be given during school time if prescription states: at noon, every four hours or every six hours. Three times a day medication will not be given during school hours.
4. Prescription medications must be in the original container with the label intact and legible. Ask your pharmacist for a bottle for school use. Medications given on a regular basis (Inhaler, Ritalin, etc.) must have the newest refill. No more than a month's supply of medication at a time will be provided to the school, unless under the discretion of the school nurse.
5. The district prohibits students from possessing or self-administering medications unless the student is allowed by law to do so and has been given permission in accordance with this section.
6. Students with health conditions such as diabetes, asthma, anaphylaxis and/or other chronic health conditions who may need to self-carry/administer medications must have a signed authorization form and be in compliance with district policy to carry such medication.
7. The school district student-occupied buildings are equipped with prefilled epinephrine auto syringes, asthma-related rescue medications and naloxone. In the event of an emergency, the school nurse or district employee may administer these medications when they believe, based on training, that a student is having a serious or life-threatening reaction or episode. If a parent or guardian wishes for their child not to receive these medications in an emergency situation written documentation must be provided to the school.
8. It is the responsibility of the parent/guardian to pick up medication when the course is complete or expires. At the end of the school year, unclaimed medication will be disposed of appropriately.
9. Parents/Guardians are responsible for updating school nurses regarding any change in health conditions or medications.

Questions concerning this policy may be directed to your school nurse.

Parent/Guardian Signature_____ Date_____