Clairton City School District

15/16. Health Office Medication and Treatment Card

20____ -- 20____

Last Name: ______________________________ First Name: ______________________________

Birthdate: ____/____/____ Male / Female Grade______ HR______

The following over-the-counter products or generic substitutes are approved by the school doctor for student use:

Antibiotic ointment (Neosporin)
Caladryl lotion
Chloraseptic spray
Visine eye drops
Orajel
Sting Kill topical anesthetic swabs
Vaseline skin and lip protectant
Mineral Ice

These non-prescription medications will be given (no more than twice a week) with signed permission only:

Acetaminophen (Tylenol) YES NO
Cough drops (Lozenges) YES NO
Ibuprofen (Advil, Motrin) YES NO
Antacid Tablets (TUMS) YES NO

A complete health history contributes to keeping your child's school health records up to date and accurate. It also helps to better understand your child's health care needs. Accurate and updated emergency contact information is vital. Please indicate any of the following and contact the school IMMEDIATELY when information changes:

Health Conditions / Medications	Yes	No	Explanation
Accidents/Serious Injury: (fractures, injuries)			
Activity Restrictions:			
Allergies: (hay fever, bee sting, food, peanuts, latex, etc.)			
Asthma: (Please include whether your child uses an inhaler)			
Concussion, Seizure, or Epilepsy:			
Emotional/Behavioral Problems:			
Glasses, Contacts, and/or Hearing Aid:			
Hospitalizations: (within the last year)			
Other Medical Conditions: (ADHD, Heart, Diabetes, High Blood Pressure, Muscular/Bone Disorders, etc.)			
Medications - Prescription &/or OTC meds taken regularly/frequently (Please list dosage & time)			
Special Examinations, Tests, or Studies within the last year: (Vision, Hearing, Neurological, X-rays, EEG, Blood tests, etc.)			
Surgery:			
Other Concerns: (something you feel the nurse should know)			

Health History Consent: The disclosure of student health information within the school is limited to that necessary to provide the student with the appropriate services to participate in school. Your signature gives permission for the nurse to inform school staff of precautions and procedures to protect your child in the classroom and to foster academic success. It is also an informed consent to share the health history information with school staff on a need-to-know basis for academic success and emergency plans as determined by the nurse.

I authorize the nurse to communicate with my medical provider or dentist regarding my child's immunizations, medications, illness or injury. I give my permission for district medically trained personnel and/or staff to use the medications and topical/external products listed above for my child. I permit necessary health information to be shared with any necessary staff members. In the event the parent(s), guardian(s), and/or emergency contact(s) cannot be reached, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment of the emergency care of my child. I will not hold the school district financially responsible for the emergency care and/or transportation of my child.

Parent/Guardian signature ______________________________ Date ____/____/____

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