ADVANCED MATH AND SCIENCE ACADEMY CHARTER SCHOOL

Student Health Office Information Sheet and Parent Permission for Over-the-Counter Medication 2024-25

*******Please complete accurately and return it promptly to the School Nurse, as this may accompany your child if emergency care is needed.***

Student's Name as it appears on Birth Certificate: **Grade Entering:** _____ **Gender:** ( ) Male ( ) Female ( ) Non Binary

_____ **Date of Birth:** _____

Last Name *First Name* *Middle name*

Address: _____**Town/City:** _____ **Zip Code:** _____

Student's Cell Phone: _____ **Primary Language:** _____ **Primary Language at Home:** _____

Who does the student live with? ( )Both Parents ( )One Parent ( )Parents share custody ( )Other (guardian)

Name and Grade of Siblings in the School Building: _____

Transportation: Bus_____ Parent Pick-up_____ Extended Day Program_____ After School Programs_____

In case of a medical emergency, the school will make attempts to contact parent/guardian before transporting your student by ambulance to an emergency facility if deemed necessary. Please complete Parent/Guardian and Medical Provider Contact Information. Your student can not be released to anyone other than those listed here:

Primary Contact #1:

Name: _____

Relationship to Student: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Email: _____

Primary Contact #2:

Name: _____

Relationship to Student: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Email: _____

Other (Custodial/Stepparent/Guardian):

Name: _____

Relationship to Student: _____

Phone: _____

Other Contact:(Local family member/Friend)

Name: _____

Relationship to Student: _____

Phone: _____

Physician's Name: _____ **Office Phone:** _____

Health Insurance Company (Name)_____ Policy # _____ ( ) None

Dentist's Name: _____ **Office Phone:** _____

Dental Insurance Company (Name)_____ Policy # _____ ( ) None

Please List any Medications your student is Currently Taking (at home and/ or at school):

_____

_____

A List of Allergies
(Medication/Food):_____

ALLERGIES: If Bee Sting or Peanut/Tree Nut/Food Allergy requires an EpiPen in School, please obtain written Medical Provider Orders, Supplies and Allergy Action Plan- send to the Health Office

Does your Child have an Epinephrine Auto-Injector: ( ) Yes

Specify Allergy: _____

ASTHMA: If needing an inhaler in school, please obtain written Medical Providers Orders, Supplies and Asthma Action Plan- send to the Health Office

Does your child have a Meter Dose Inhaler: ( ) Yes

Specify (Kind /Use/ How Often):

_____

DIABETES: Please obtain written Medical Provider Orders, Supplies and Diabetes Action Plan- send to the Health Office

Please specify any medication or treatment your child will/may need during school hours:

_____

Seizures: Please obtain written Medical Orders, Seizure Action Plan- send to the Health Office

Please specify any medication or treatment your child will/may need during school hours:

_____

Please Mark any Health Concerns that apply to your Child and explain (Medication/Treatment).List a Specialist Name if under care.

( ) Vision(Glasses/Contacts)_____ ( ) Hearing (Aids) _____ ( ) Speech_____

( ) Dental _____ ( ) Scoliosis _____( ) Muscular _____

( ) Headaches_____ ( ) Migraines_____ ( ) Asthma_____

( ) Allergies_____ ( ) Neurological Concerns _____ ( ) Seizures _____

( ) Concussion History_____ ( ) Diabetes _____ ( ) Heart Condition _____

( ) Gastro Intestinal Issues _____( ) ADD/ADHD _____

( ) Emotional, Behavioral or Mental Health Concerns _____

( ) Other Health Conditions _____

( ) Physical Limitations, Special Equipment _____

I give the school nurse permission to share this information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment. ( ) Yes ( ) No

In case of an emergency or serious injury and I cannot be reached at the phone numbers provided, I authorize the school to arrange transportation to the nearest hospital emergency room to be treated.

Signature (custodial parent/guardian): _____ Date: _____

Parental Permission for Over- The- Counter Medication (OTC) Orders 2024-25

In accordance with the AMSA standing orders and protocols signed by school physician, Dr. Angela Hunt, M.D., the medications listed below will be dispensed with written permission from a parent or guardian. Your child may receive up to three (3) doses each school year of OTC medications - these medications are intended for very infrequent use. No medication will be dispensed if your child exhibits a fever, or any signs of an illness/ or condition that warrants a medical provider's assessment. Other pain relief methods such as ice/heat packs, rest and hydration/snack will be used before medication is offered. Any child needing more than 3 doses per school year is required to obtain a medical provider's orders.

My child has permission to receive the medication(s) checked below. I understand this medication will be given only after the nurse(s) have made an assessment and determined it is appropriate:

( ) Ibuprofen 400 mg, for relief of pain ( ) Acetaminophen 650mg, for relief of pain ( ) Throat Lozenge, for relief of sore throat/cough

( ) Caladryl, for topical itch relief ( ) Vaseline (petrolatum) or lip balm for chapped lips or wound care

Please call me every time my child receives a dose of medication ( ) Yes ( ) No Phone #_____

Parent/Guardian Signature: _____ Date: _____